PROVIDENT LIFE and ACCIDENT INSURANCE COMPANY

1 Fountain Square
Chattanooga, TN 37402

APPLICATION FOR TERM VOLUNTARY LIFE INSURANCE

APPLYING FOR:

☐ Employee (Applicant) Coverage
☐ Spouse Coverage

Please Print

Section A: EMPLOYEE (Applicant) Information - Always complete.

1. Name (First) (Middle) (Last)
2. Social Security No.
3. Residence Address (Street/Box No.) (City) (State) (Zip)
4. Birthdate
5. Age
6. Sex ☐ F ☐ M
7. Home Phone Number
8. Employer's Name
9. Employment Date
10. Are you actively at work? ☐ Yes ☐ No
11. Employee/Payroll No.

If applying for Employee (Applicant) Policy, please complete the following:

12. Have you used any tobacco products (cigarettes, cigars, snuff/dip/chew, pipe) and/or any nicotine delivery systems within the last 12 months?.......... ☐ Yes ☐ No
13. Primary Beneficiary/Relationship
14. Contingent Beneficiary/Relationship

Section B: SPOUSE Information (Complete ONLY if applying for Spouse coverage)

15. Name (First) (Middle) (Last)
16. Coverage Type ☐ Policy or ☐ Rider
17. Birthdate
18. Age
19. Sex ☐ F ☐ M
20. Occupation
21. Has Spouse been hospitalized or unable to perform the normal duties and activities of a person of like age which are in no way curtailed or altered within the last 6 months? ☐ Yes ☐ No .... **(If "Yes", complete Section D)**

If applying for Spouse Policy, please complete the following:

22. Primary Beneficiary/Relationship
23. Contingent Beneficiary/Relationship

Section C: POLICY Information - To be completed for Employee (Applicant) and Spouse Policy coverage.

	Employee(Applicant)	Spouse
24. Will coverage applied for replace or modify any existing life insurance or annuity coverage?	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes", Give Company Name..........	______	______
25. Face Amount of Coverage (Plan is 10/10 YRT; unless age 61 or older then 10/YRT)..........	$ ______	$ ______
26. **Base Policy Premium**..........	$ ______	$ ______
Riders and Premiums:		
☐ ADB	$ ______	$ ______
☐ Children's Term (# of Units ____) Cannot be on both the employee & spouse policy..........	$ ______	$ ______
☐ Spouse Term..........	$ ______	Not Applicable
☐ Waiver of Premium..........	$ ______	Not Applicable
☐ Other ______	$ ______	$ ______
☐ Other ______	$ ______	$ ______
Payroll Premium Deducted: ☐ Weekly ☐ Bi-Weekly Total:	$ ______	$ ______
☐ Semi-Monthly ☐ Monthly ☐ Other ______		

TOTAL PAYROLL PREMIUM: $ ______

Employee Name: ______________________ Employee SSN: __________
(Applicant) (Applicant)

SECTION D: MODIFIED GUARANTEED ISSUE: EMPLOYEE (Applicant) and/or SPOUSE Coverage
(Complete as required for all applicants, in addition to previous questions)

	Employee(Applicant)	Spouse
27. Have you ever tested positive for the HIV virus, its antibodies, or been diagnosed with or received treatment for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
28. In the last 12 months, have you:		
(a) Been diagnosed with or treated for cancer, renal failure, insulin dependent Diabetes or chronic Hepatitis?	☐ Yes ☐ No	☐ Yes ☐ No
(b) Been diagnosed with or treated for chronic lung disease, schizophrenia or manic depressive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
(c) Had heart surgery, or been diagnosed or treated for a heart attack or a stroke?	☐ Yes ☐ No	☐ Yes ☐ No
(d) Been convicted for drug and/or alcohol abuse or DUI or DWI?	☐ Yes ☐ No	☐ Yes ☐ No
(e) Had a recurrent disability, been disabled or are you disabled now?	Not Applicable	☐ Yes ☐ No

SECTION E: SIMPLIFIED ISSUE LEVEL 1: EMPLOYEE (Applicant) Policy Only
Complete as required in addition to previous questions)

29. Annual Salary	30. Height	31. Weight
$	ft. in.	lbs.

32. Have you ever had or been treated for: stroke, congestive heart failure, chronic lung disease (including emphysema), insulin-dependent diabetes, hepatitis (other than type A), cirrhosis of the liver, renal hypertension or failure, systemic lupus or any connective tissue disease? ☐ Yes ☐ No

33. In the last 5 years, have you been diagnosed or treated for: psychosis, internal cancer (including melanoma), leukemia or Hodgkin's disease, alcoholism or drug abuse, or had heart surgery, heart attack or transient ischemic attack (TIA)? ☐ Yes ☐ No

34. In the last 2 years, have you been put on probation or convicted of a felony, misdemeanor, DUI or DWI? ☐ Yes ☐ No

EMPLOYEE (APPLICANT) STATEMENTS

I understand that coverage issued is based on all statements and answers recorded above. I agree that any child proposed for Children's Term Insurance must be dependent on me for at least 50% of his/her support to be covered for benefits. These statements are complete and true. I understand that as the undersigned, I am the owner of any coverage issued under this application.

Insurance will become effective as of my application signed date. Coverage will remain in effect unless Provident determines that the proposed insured(s) is(are) not a risk acceptable under its rules, limits and standards for the plan and amount applied for without modification. In such event, you will be notified.

I authorize my employer to deduct the premiums for this insurance from my earnings (unless I have completed additional forms for a non-payroll method).

Dated ______________________ at ______________________
(Month/Day/Year) (City, State)

Employee (Applicant) Signature

☐ If this box is checked, a PIN # secured enrollment has authorized the application and a signature is not required.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.

Employee Name: ______________________________ Employee SSN: ______________
(Applicant) (Applicant)

AGENT STATEMENTS : (1) Do you have knowledge or reason to believe that the proposed insurance is intended to replace any existing insurance or annuities? ☐ Yes ☐ No (2) To the best of your knowledge and belief, the above statements and answers are complete and true.

Dated ______________________
(Month/Day/Year)

Licensed Agent's Signature

Agents' License No. ______________________

Printed Name of Agent ______________________

Policy Number:
Employee (Applicant) ______________
Spouse ______________