**Provident Life and Accident Insurance Company**
1 Fountain Square • Chattanooga, Tennessee 37402

**APPLICATION FOR INDIVIDUAL VOLUNTARY LIFE INSURANCE / LONG TERM CARE INSURANCE**

**Product Type:**
☐ WL ☐ TERM *
☐ IUL ☐ IUL Increase

| | Employee (Applicant) | Spouse | Child and/or Grandchild* |
|---|---|---|---|
| **New Coverage** | ☐ | ☐ | ☐ |
| **Addition of Coverage** | ☐ | ☐ | ☐ |
| **Reinstatement** | ☐ | ☐ | ☐ |

*Child/Grandchild Policy not available with TERM

## SECTION 1: EMPLOYEE (APPLICANT) INFORMATION – Always Complete

Employee Name (First, Middle, Last) _____

Social Security Number _____

Home Address (Street/PO Box) _____

Gender ☐ F ☐ M

City _____

Date of Birth (mm/dd/yyyy)

State _____ Zip Code _____ _____

Home Phone # _____

Employee ID/Payroll # _____

Are you Actively at Work? ☐ Yes ☐ No

Are you a U.S. Citizen or Canadian Citizen working in the U.S.?
☐ Yes ☐ No If "No," do you have a Green Card? ☐ Yes ☐ No

Employer Name _____

Date of Hire (mm/dd/yyyy) _____

Scheduled Number of Work Hours per Week _____

Annual Salary $ _____

Occupation _____

Work Phone # _____

## SECTION 2: SPOUSE INFORMATION– Complete Only if applying for Spouse coverage (Policy or Spouse Term Rider)

Name (First, Middle, Last) _____

Social Security Number _____

Occupation _____

Gender ☐ F ☐ M

Does the Spouse live in the U.S.? ☐ Yes ☐ No

Date of Birth (mm/dd/yyyy) _____

Within the past 12 months, has the spouse been admitted to a hospital or missed 5 or more consecutive days of work for any reason other than vacation, colds, flu, pregnancy, accidents, allergies, back or knee disorder?

☐ Yes ☐ No **(If "Yes" and applying for Tier 1 amount, complete Section 5; If "Yes" and applying for Tier 2 amount, complete Sections 5 & 6)**

Employee Name: (Applicant) _____ Employee SSN: (Applicant) _____

## SECTION 3: CHILD and/or GRANDCHILD – Complete Only if applying for Child and/or Grandchild Policy (Child/Grandchild Policy not available with TERM)

**Child/Grandchild #1**

Name (First, Middle, Last) _____ Relationship: ☐ Child ☐ Grandchild

Address _____ SS# _____

Date of Birth (mm/dd/yyyy) _____ Gender ☐ F ☐ M

Does the Child/Grandchild live in the U.S.? ☐ Yes ☐ No

**Child/Grandchild #2**

Name (First, Middle, Last) _____ Relationship: ☐ Child ☐ Grandchild

Address _____ SS# _____

Date of Birth (mm/dd/yyyy) _____ Gender ☐ F ☐ M

Does the Child/Grandchild live in the U.S.? ☐ Yes ☐ No

## SECTION 4: COVERAGE INFORMATION – To be completed for Employee (Applicant), Spouse, Child and/or Grandchild coverage (Child/Grandchild Policy not available with TERM)

| | Employee (Applicant) | Spouse | Child/Grandchild #1 | Child/Grandchild #2 |
|---|---|---|---|---|
| 1. Have you (or any person applying for coverage) used any tobacco products (such as cigarettes, cigars, snuff, dip, chew or pipe) or any nicotine delivery system in the past 12 months? **(If Spouse and applying for a TERM Policy, this question is not required)** | ☐ Yes ☐ No | ☐ Yes ☐ No | N/A | N/A |
| 2a. Do you (or any person applying for coverage) have existing individual life insurance or annuity coverage? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. Will coverage applied for replace any existing individual life insurance or annuity coverage? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If "Yes," provide details requested on the accompanying replacement form, if required. | | | | |

Employee Name: _____ Employee SSN: _____
(Applicant) (Applicant)

**SECTION 4: COVERAGE INFORMATION Continued – To be completed for Employee (Applicant), Spouse, Child and/or Grandchild coverage (Child/Grandchild Policy not available with TERM)**

| | | Employee (Applicant) | Spouse | Child/Grandchild #1 | Child/Grandchild #2 |
|---|---|---|---|---|---|
| 3. Plan of Insurance being applied for | WL – Pay All Years | ☐ | ☐ | ☐ | ☐ |
| | WL – Pay to Age 70 | ☐ | ☐ | ☐ | ☐ |
| | If WL, APL? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | IUL/Increase | ☐ | ☐ | ☐ | ☐ |
| | TERM | ☐ | ☐ | N/A | N/A |
| 4. Face/Specified Amount | | $ _____ | $ _____ | $ _____ | $ _____ |
| 5. Base Policy Premium | | $ _____ | $ _____ | $ _____ | $ _____ |

6. Riders and Premiums

| | Employee (Applicant) | | Spouse | |
|---|---|---|---|---|
| | Coverage Amount | Premium | Coverage Amount | Premium |
| ☐ ADB | $ _____ | $ _____ | $ _____ | $ _____ |
| ☐ Waiver* | | $ _____ | | |
| ☐ CTR** | # of Units _____ | $ _____ | # of Units _____ | $ _____ |
| ☐ AIR (IUL only) | $ _____ For _____ yrs. | | | |
| ☐ LTC*** | | $ _____ | | $ _____ |
| ☐ BC | | $ _____ | | $ _____ |
| ☐ BR | | $ _____ | | $ _____ |
| ☐ BC/BR | | $ _____ | | $ _____ |
| ☐ Spouse Term Rider | $ _____ | $ _____ | | |
| ☐ Level Term Rider | $ _____ | $ _____ | | |
| ☐ Other _____ | $ _____ | $ _____ | $ _____ | $ _____ |
| 7. Total Premium for Riders | | $ _____ | | $ _____ |

8. Total Premium for Base Policy and Riders (Provide sum for #5 and #7 for each applicant)
   - Employee (Applicant) $ _____
   - Spouse $ _____
   - Child/Grandchild #1 $ _____
   - Child/Grandchild #2 $ _____
   - Combined Total for All Applicants $ _____

9. Payroll Premium Deducted:

☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

TOTAL PAYROLL PREMIUM: ..... $ _____

* IUL – Waiver of Monthly Deduction
WL and TERM – Waiver of Premium

** CTR cannot be on both the Employee and Spouse Policies

*** LTC not available with TERM Policy

Employee Name: _____ Employee SSN: _____
(Applicant) (Applicant)

## SECTION 4: COVERAGE INFORMATION Continued

### BENEFICIARY INFORMATION – Employee (Applicant)

Primary Beneficiary:

Name (First, Middle, Last) _____ Relationship to You _____

Address _____ SS# _____ Telephone _____ DOB _____

Contingent Beneficiary:

Name (First, Middle, Last) _____ Relationship to You _____

Address SS# Telephone DOB

### BENEFICIARY INFORMATION – Spouse

Primary Beneficiary:

Name (First, Middle, Last) _____ Relationship to You _____

Address _____ SS# _____ Telephone _____ DOB _____

Contingent Beneficiary:

Name (First, Middle, Last) _____ Relationship to You _____

Address SS# Telephone DOB

### BENEFICIARY INFORMATION – Child/Grandchild #1

Primary Beneficiary:

Name (First, Middle, Last) _____ Relationship to You _____

Address _____ SS# _____ Telephone _____ DOB _____

Contingent Beneficiary:

Name (First, Middle, Last) _____ Relationship to You _____

Address SS# Telephone DOB

### BENEFICIARY INFORMATION – Child/Grandchild #2

Primary Beneficiary:

Name (First, Middle, Last) _____ Relationship to You _____

Address _____ SS# _____ Telephone _____ DOB _____

Contingent Beneficiary:

Name (First, Middle, Last) _____ Relationship to You _____

Address SS# Telephone DOB

To name a Secondary Addressee, Please furnish the name and address:

_____

_____

_____

Employee Name: _____ Employee SSN: _____
(Applicant) (Applicant)

| SECTION 5: TIER 1 MEDICAL PROFILE – Complete as required for all underwritten coverage (Child/Grandchild Policy not available with TERM) | Employee (Applicant) | Spouse | Child/Grandchild #1 | Child/Grandchild #2 |
|---|---|---|---|---|
| 1. Have you (or any person applying for coverage) tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Within the past 12 months, have you (or any person applying for coverage) been admitted to a hospital or missed 5 or more consecutive days of work for any reason other than vacation, colds, flu, pregnancy, accidents, allergies, back or knee disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. Has the Child or Grandchild applicant ever been diagnosed with or treated by a member of the medical profession for Down's syndrome, cerebral palsy, muscular dystrophy or cystic fibrosis? | N/A | N/A | ☐ Yes ☐ No | ☐ Yes ☐ No |

Employee Name: _____ Employee SSN: _____
(Applicant) (Applicant)

| SECTION 6: TIER 2 MEDICAL PROFILE – Complete if additional underwriting is required | Employee (Applicant) | Spouse |
|---|---|---|
| 1. Provide height and weight | ___ ft. ___ in.<br>___ lbs. | ___ ft. ___ in.<br>___ lbs. |
| 2. Have you (or any person applying for coverage) ever been diagnosed by or received medical advice from a member of the medical profession, sought treatment including surgery, or taken medication for any of the following:<br>- Cirrhosis of the liver or hepatitis (excluding hepatitis A)<br>- Kidney disease or failure (excluding kidney stones, sponge, horseshoe or ectopic kidney and kidney removal due to trauma)<br>- Atrial fibrillation, angina, heart attack, coronary artery disease or surgery on the heart or heart valve(s)<br>- Congestive heart failure or cardiomyopathy<br>- Stroke or transient ischemic attack (TIA)<br>- Peripheral Vascular Disease<br>- Cancer (excluding basal cell carcinoma)<br>- Any condition requiring an organ transplant (excluding corneal)<br>- Diabetes (excluding gestational or diet controlled)<br>- Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma) | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No |
| 3. In the past 5 years, have you (or any person applying for coverage) been diagnosed by or received medical advice from a member of the medical profession, sought treatment including surgery, or taken medication for any of the following:<br>- Multiple sclerosis, muscular dystrophy or Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) or Huntington's disease<br>- Schizophrenia, psychosis, bipolar disorder or post traumatic stress disorder<br>- Crohn's disease or ulcerative colitis<br>- Systemic lupus or any connective tissue disease | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No |
| 4. In the past 2 years, have you (or any person applying for coverage):<br>- Pled guilty or no contest or been convicted of a felony or misdemeanor<br>- Been charged with operating a motor vehicle under the influence of drugs and/or alcohol | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No |

Employee Name: _____ Employee SSN: _____
(Applicant) (Applicant)

| SECTION 7: LONG TERM CARE RIDER – Complete Only if applying for LTC Rider | Employee (Applicant) | Spouse |
|---|---|---|
| 1. Do you (or any person applying for coverage) have another long term care insurance policy in force, including health care service contract, or health maintenance organization contract? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Did you (or any person applying for coverage) have another long term care insurance policy in force during the past 12 months?<br>If "Yes," with which company:<br>_____<br>If it has lapsed, when did it lapse?<br>_____ | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. Are you (or any person applying for coverage) covered by Medicaid (not Medicare)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Do you (or any person applying for coverage) intend to replace any long term care, medical, or health coverage with this rider?<br>If "Yes," type of coverage:<br>_____<br>Name of Company<br>_____ | ☐ Yes ☐ No | ☐ Yes ☐ No |

Employee Name: _____ Employee SSN: _____
(Applicant) (Applicant)

## SECTION 8: EMPLOYEE (APPLICANT) AGREES AS FOLLOWS:

The effective date of coverage issued based on this application is subject to: (1) the application being acceptable under the rules, limits and standards of Provident Life and Accident Insurance Company (hereafter called "Unum"); and (2) the insurance is, or would have been, issued as applied for. (If not issued as applied for, then as modified.) The effective date of coverage will be stated in your policy. This date will be: (1) no earlier than the date the application is signed; and (2) no later than the date: (a) payroll deductions begin; or (b) premiums are collected for non-payroll deducted policies.

If applying for any Long Term Care rider, I have received the following items, as applicable: (1) Outline of Coverage, (2) Things You Should Know Before You Buy Long-Term Care Insurance; and (3) Potential Rate Increase Disclosure Form. No benefits are payable for the first 90 days of a Benefit Period under any Long Term Care rider for which I may be applying.

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.

My employer is authorized to deduct the premiums for this insurance from my earnings. This authorization is given unless an alternate method to pay insurance premium is allowed. I am the owner of any coverage issued under this application.

I have read this application. The answers and statements above are true and complete to the best of my knowledge and belief. These answers and statements are the basis for any policy issued. No information about the applicant will be considered to have been given to Unum unless it is stated in the application.

**CAUTION:** Unum relies on the information provided to evaluate this application. If the answers provided are incorrect or untrue, Unum may deny benefits or rescind insurance. Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application or files a claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

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

| **Employee (Applicant) Signature** | **Spouse Signature (if applicable)** |
|---|---|
| **Child Signature (if applicable for age of majority and older)** | |

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries. The insurance product is underwritten by Provident Life and Accident Insurance Company.

**PRODUCER STATEMENTS:** (1) Do you have any knowledge or reason to believe that the applicant has any existing individual life insurance, long term care insurance or annuity coverage? ☐ Yes ☐ No (2) Do you have knowledge or reason to believe that the proposed insurance is intended to replace any existing individual life insurance, long term care insurance or annuity coverage? ☐ Yes ☐ No (3) To the best of your knowledge and belief, the above statements and answers are complete and true.

Dated _____
(Month/Day/Year)

Producer's License No. _____

Printed Name of Producer _____

**Licensed Producer's Signature**

**For Home Office Use Only**

Policy Number: _____

Employee (Applicant) _____

Spouse _____

Child/Grandchild #1 _____

Child/Grandchild #2 _____