PROVIDENT LIFE and ACCIDENT INSURANCE COMPANY

1 Fountain Square
Chattanooga, TN 37402

APPLICATION FOR VOLUNTARY SPECIFIED CRITICAL ILLNESS INSURANCE
Limited Benefit Individual Health Coverage

☐ New Coverage
☐ Additional Coverage

THIS IS A LIMITED BENEFIT POLICY. YOU SHOULD HAVE COMPREHENSIVE HEALTH COVERAGE BEFORE PURCHASING THIS POLICY.

Please Print

Section A: EMPLOYEE (Primary Insured) 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.

12. Occupation | 13. Scheduled Number of Work Hours per Week | 13a. Monthly Salary $

14. Primary Beneficiary/Relationship | 15. Contingent Beneficiary/Relationship

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

16. Name (First) (Middle) (Last)

17. Birthdate | 18. Age | 19. Sex ☐ F ☐ M | 20. Occupation

21. Primary Beneficiary/Relationship | 22. Contingent Beneficiary/Relationship

Section C: COVERAGE Information - To be completed for Employee (Primary Insured) Policy and for Spouse Rider.

	Employee (Primary Insured)	Spouse
23. 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	☐ Yes ☐ No
24. a. Will coverage applied for replace or modify any existing health insurance?	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes", Give Company Name _____		
b. Does any proposed insured have comprehensive health coverage? If "no", the proposed insured is not eligible for coverage.	☐ Yes ☐ No	☐ Yes ☐ No

	Employee (Primary Insured)	Spouse Rider	Child Rider	Premium
25. Critical Illness - Face Amount	$ _____	$ _____	$ _____	
Critical Illness - Premium	$ _____	$ _____	$ _____	$ _____
☐ Health Screening Benefit Rider	$ _____	$ _____	$ _____	$ _____
☐ Cancer and Carcinoma in Situ Rider	$ _____	$ _____	$ _____	$ _____
☐ Other	$ _____	$ _____	$ _____	$ _____
☐ Other	$ _____	$ _____	$ _____	$ _____

Payroll Premium Deducted: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____ **Total:** $ _____

TOTAL PAYROLL PREMIUM: $ _____

Employee Name: _____ Employee SSN: _____
(Primary Insured) (Primary Insured)

SECTION D: MODIFIED ISSUE: EMPLOYEE (Primary Insured), Spouse Rider, and/or Child Rider. (Complete question 28. only if applying for Cancer Rider)

In the past 10 years, have you:	Employee/ Primary Insured	Spouse Rider	Child Rider ($5000)
26. Been diagnosed with or sought medical treatment for: heart attack, cardiovascular condition, stroke, organ transplant, chronic kidney(renal) disorder/kidney (renal) disease, emphysema, or insulin dependent diabetes?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
27. Been prescribed three or more medications to be taken concurrently for high blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
28. Been diagnosed with any of the following: internal cancer including leukemia, Hodgkin's disease, melanoma (Clark's Level 3, 4, or 5) or malignant tumors of any kind?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION E: SIMPLIFIED ISSUE: EMPLOYEE (Primary Insured) Policy Only (Complete in addition to previous questions. If "Yes" to any question, please provide details in question 35 below)

29. Height ft. in. 30. Weight lbs

Have you:

31. In the past 10 years tested positive for HIV virus or its antibodies, or been diagnosed with or received treatment for acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? ..... ☐ Yes ☐ No

32. Within the past 12 months been hospitalized as an inpatient: (a) three or more times; or (b) for 10 or more days (not related to pregnancy)? ..... ☐ Yes ☐ No

33. In the past 10 years been treated or received medical advice for: liver disorder including cirrhosis or hepatitis (other than type A) or any heart, lung, respiratory, or circulatory disorder not listed above? ..... ☐ Yes ☐ No

34. List name and dosage of all medication currently taken (medications includes all prescriptions, over the counter drugs and natural supplements):

_____

_____

_____

_____

35. Condition	Medication	Date of Onset	Doctor's/Hospital's Name and Address	Dates of Treatment	Treatment Received

36. Have you received an Outline of Coverage form? ..... ☐ Yes ☐ No

Employee Name: _____ Employee SSN: _____
(Primary Insured) (Primary Insured)

EMPLOYEE (PRIMARY INSURED) STATEMENTS

I understand that coverage issued is based on all statements and answers recorded above. I agree that any child proposed for rider coverage 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.

I understand that the effective date of insurance under this policy will be the date the application was signed if the application is acceptable under the Company's rules, limits or standards and the insurance is, or would have been, issued (or if not acceptable, then as modified).

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)

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

Employee (Primary Insured) Signature

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.

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.

Licensed Agent's Signature

Dated _____
(Month/Day/Year)

Agents' License No. _____

Printed Name of Agent _____

Policy Number:

Employee (Primary Insured) _____

For Home Office Use Only

Employee Name: _____ Employee SSN: _____
(Primary Insured) (Primary Insured)

INSTRUCTIONS

Complete the information below only if you or any person proposed for coverage on the preceding application is currently eligible for Medicare. To be eligible for Medicare, you must be either: (1) age 65 or older; or (2) disabled.

Medicare Certification Form

This is to certify that I have received the "Guide to Health Insurance for People with Medicare" and the "Important Notice to Persons on Medicare".

_____ _____
Date Signature of Applicant