unum

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? If "Yes," provide details requested on the accompanying replacement form, if required.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Employee Name: (Applicant) _____ Employee SSN: (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) Coverage Amount	Employee (Applicant) Premium	Spouse Coverage Amount	Spouse 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: (Applicant) _____ Employee SSN: (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: (Applicant) _____ Employee SSN: (Applicant) _____

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

IMPORTANT NOTICE
Provident Life and Accident Insurance Company
1 Fountain Square, Chattanooga, TN 37401

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ❑ YES ❑ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ❑ YES ❑ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the existing insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	EXISTING INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.

Where a replacement is involved in the transaction, you have the right to return the policy or contract issued within thirty (30) days of the delivery of the policy or contract and receive an unconditional full refund of all premiums or considerations paid on it, including policy fees or charges.

I have used only company approved sales material. If applicant has indicated that this will be replacement coverage, copies of all sales material were left with the applicant.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ Applicant's Signature

_____ Applicant's Printed Name Date

_____ Applicant's Social Security Number

_____ Producer's Signature

_____ Producer's Printed Name Date

_____ Applicant's Employer

I do not want this notice read aloud to me. _____(Applicants must initial only if they do not want the notice read aloud.)

(SEE REVERSE SIDE)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?

Could they change?

You're older - are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax free exchange? (See your tax advisor)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

(SEE REVERSE SIDE)