



STATE OF TENNESSEE
 APPLICATION FOR
 OPTIONAL TERM LIFE
 OPTIONAL UNIVERSAL LIFE
 Provident Life and Accident Insurance Company
 Chattanooga, TN 37402

Application Type: Annual Enrollment New Hire

SECTION 1: Employee Information – Always Complete		
Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender <input type="checkbox"/> F <input type="checkbox"/> M
City		Date of Birth (mm/dd/yyyy)
State	ZIP Code	Daytime Phone
Email Address		Cell Phone
Employee Annual Base Salary \$		Date of Hire (mm/dd/yyyy)

SECTION 2: Certificate Information

Employee Coverage
 Minimum - \$5,000
 Maximum - Five times your annual base salary, rounded to the next higher multiple of \$5,000 up to \$300,000. A supplemental application must be completed and submitted for amounts over three times annual base salary.

<i>Term Life</i>		<i>Universal Life</i>	
Employee Coverage Amount \$		Employee Coverage Amount \$	
Beneficiary	Relationship	Beneficiary	Relationship
Address	Percentage	Address	Percentage
Beneficiary	Relationship	Beneficiary	Relationship
Address	Percentage	Address	Percentage

Children's Coverage
 Children's coverage will be automatically attached to the employee certificate if employee coverage is selected. Children's coverage is only available on the term certificate, unless only universal life coverage is selected. If coverage is attached to the employee certificate, it cannot be attached to the spouse certificate. If selecting children's coverage, please complete section 5.

Children's Term Rider 2,500 5,000

SECTION 3: Spouse Information – Always show name – Fully Complete for Coverage

Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender <input type="checkbox"/> F <input type="checkbox"/> M
City		Date of Birth (mm/dd/yyyy)
State	ZIP Code	

Has spouse been hospitalized, advised to seek medical treatment, or received disability benefits during the last 6 months?
 Yes No

If yes, submit supplemental application.

SECTION 4: Spouse Certificate Information

Spouse Coverage

Minimum - \$5,000

Maximum - Less than Age 55: one times employee's annual base salary up to \$30,000 in \$5,000 increments

Maximum - Ages 55 and Over: \$15,000

Term Life Spouse Coverage Amount \$		Universal Life Spouse Coverage Amount \$	
Beneficiary	Relationship	Beneficiary	Relationship
Address	Percentage	Address	Percentage
Beneficiary	Relationship	Beneficiary	Relationship
Address	Percentage	Address	Percentage

Children's Coverage

Please note you can not add children's coverage to the spouse certificate if children's coverage has already been added to employee certificate.

Children's coverage is only available on the term certificate, unless only universal life coverage is selected.

If selecting children's coverage, please complete section 5.

Children's Term Rider 2,500 5,000

SECTION 5: Children Information – Complete only if dependent children's insurance chosen

List eligible dependent children as defined in the plan.

Child's Name First, Middle, Last	Social Security Number	Date of Birth (mm/dd/yyyy)	Issue Age	Gender M or F	Relationship to Employee

The beneficiary of children's term insurance is the employee, if living, otherwise the estate of the covered child.

I certify that the information on this application is true and complete and that I am Actively at Work/Positive Pay Status on the date of my signature below. I understand that if I have selected insurance for myself, it will begin on the Certificate Issue Date; provided I am Actively at Work/Positive Pay Status on that date.

Dependent Spouse and/or Dependent Children's Coverage, if selected, will begin on the Certificate Issue Date; provided: (1) I am Actively at Work/Positive Pay Status on that date; and (2) my Dependent Spouse and/or Dependent Child(ren) is/are able to engage in normal activities on the date the coverage is to become effective.

I understand that I, as the Employee, am the owner of all coverages applied for. I authorize my Employer to deduct the proper premiums for this insurance from my earnings.

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.

Employee Signature _____ Date _____

FOR HOME OFFICE USE ONLY

DEDUCTION AMOUNT: E _____ S _____ C _____ TD _____

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