RESET

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
1 FOUNTAIN SQUARE
CHATTANOOGA, TN 37402 (Herein called "Provident")
A subsidiary of Unum Group

Please Print or Type

SUPPLEMENTAL APPLICATION FOR OPTIONAL LIFE INSURANCE FOR THE STATE OF TENNESSEE

Check One: ❑ Universal Life ❑ Term Life

Employee Last Name First Middle Employee Social Security No.

$ Employee Annual Base Salary (does not include overtime pay, longevity, etc.)

Employee Daytime Telephone No. (REQUIRED)

Proposed Insured (Employee, Spouse, Child) Last Name First Middle Budget Code

Home Address Date of Birth State of Birth

City - State - Zip Code Occupation _____ Ft. ____ In. Height _____ lbs. Weight

PLEASE COMPLETE **ONLY** IF APPLYING FOR AN INCREASE IN EXISTING COVERAGE

Currently Insured by Provident for $_____ Additional Amount Requested $_____

THE FOLLOWING REPRESENTATIONS SHALL FORM A BASIS FOR PROVIDENT'S APPROVAL OR REJECTION OF THIS APPLICATION

Every Question Must Be Answered **Yes** **No**

1. Will any existing life or annuity contracts be lapsed or changed if the proposed insurance is issued? ..... ❑ ❑
2. In the past 10 years, have you had high blood pressure or heart disease, cancer or tumor of any kind; epilepsy or nervous disorder; diabetes; lung or respiratory disorder; kidney or liver disorder? ..... ❑ ❑
3. Have you ever been diagnosed by or received treatment from a member of the medical profession as having "AIDS" (Acquired Immune Deficiency Syndrome) or ARC?..... ❑ ❑
4. Are you now receiving treatment or taking medication of any kind?..... ❑ ❑
5. In the past 5 years, have you received advice, treatment, or been arrested for the use of alcohol, or the use or possession of any narcotic, stimulant, sedative or hallucinogenic drug?..... ❑ ❑
6. In addition to conditions in Questions 1–5, have you consulted any doctors or been a patient in any hospital in the past 5 years? ..... ❑ ❑

Give complete details below for any questions answered "Yes".

Question Number	Condition Details	Date and Duration of Disability	Name and Addresses of Physicians and Hospitals

All statements and answers recorded on this application are true and complete. I understand that the optional life insurance coverage I have selected will become effective on the later of: (1) The Certificate Issue Date; or (2) Approval of this application; provided:
(a) For Employee Coverage: I am Actively at Work/Positive Pay Status on the date my application is signed AND on the date my coverage is to become effective; and
(b) For Dependent Spouse and/or Dependent Children Coverage: I am Actively at Work/Positive Pay Status on the date my application is signed and the date coverage is to become effective AND 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.

AUTHORIZATION: The Proposed Insured authorizes the following, who have records or knowledge of him/her or his/her health, to release such information to Provident, or its reinsurers: any (1) Licensed physician or medical practitioner; (2) Clinic, hospital, or other medical or medically related facility; (3) Insurance company; (4) The Medical Information Bureau; or (5) Other person, organization, or institution. This authorization also applies to any Eligible Child, if applicable. Information may be testified to, to the extent permitted by law. This authorization will be valid for 30 months from the date shown below. A photographic copy of this authorization will be as valid as the original. Receipt of the Notice of Information Practices attached to this application is also acknowledged.

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.

Signature of Proposed Insured (if other than Employee) _____ Date _____

Signature of Employee _____ Date _____

Agency Name _____ Budget Code _____

Agency Benefits Coordinator Signature _____ Date _____

Email Address _____ Phone _____

Agency Benefits Coordinator Signature above verifies applicant's eligibility for life coverage.

M-95202 (11/07)

NOTICE OF INFORMATION PRACTICES

(Including Medical Information Bureau (MIB) Notice and Fair Credit Reporting Act Notice)

This Notice Must Be Given to Proposed Insured

In considering your application, information from various sources will be considered. These include your statements, the results of your physical examination (if required) and reports we get from doctors or medical facilities which have attended you.

Information about your insurability will be treated as confidential. Provident, or our reinsurers, may, however, make a brief report of this to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426–3660.

We, or our insurers, may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom a claim is submitted.

In addition, we may get an investigative report from a consumer reporting agency. This report requires personal interviews with your neighbors, friends, or other acquaintances for information as to your general reputation, personal characteristics and mode of living. As part of your application, you have authorized us to do this. You have the right to be personally interviewed and to make a written request within a reasonable period about the nature and scope of this investigation. Upon written request you will be told if such a report has actually been ordered, and if it has, we will give you the name and address of the consumer reporting agency. You may contact this consumer reporting agency and ask for a copy of such report.

Unless we are required to do so by law, the information we get in this report as well as any other information which we later acquire, will not be disclosed to anyone else without your consent. You may request a copy of all information acquired by us and have a right to correct any personal information which you feel is inaccurate. We will, if required by law, give you a more detailed notice of the types of personal information which we get in considering your application, as well as any additional rights which you may have.

If you need any assistance, please feel free to contact us at Provident Life and Accident Insurance Company, Attention: Voluntary Benefits Division (3–S) Chattanooga, Tennessee 37402–1338.