



**EVIDENCE OF INSURABILITY APPLICATION FOR COVERAGE**

Late Enrollee  Yes  No

Provident Life and Accident Insurance Company  
 1 Fountain Square, Chattanooga, TN 37402  
 18 Chestnut Street, Worcester, MA 01608-1528

**LIFE COVERAGE REQUESTED**

- Basic Life
- Additional Life
- Dependent Life
- Group Voluntary Term Life

**DISABILITY COVERAGE REQUESTED**

- LTD  STD
- Excess LTD

**DIRECTIONS:** This form must be completed in its entirety whenever evidence of insurability is required, whether due to late enrollment or due to application for amounts of coverage in excess of the guaranteed issue amount. Additional medical information may be required including but not limited to a medical examination, blood profile, and urinalysis. It is the Applicant's responsibility to read, complete, date and sign this form. Failure to complete this form completely and accurately may have an adverse effect on insurability. This form is valid for no more than 60 days from the date signed by the Applicant.

Name of Company Representative		Phone Number ( ) -	
Name of Policyholder (Employer's Name or Association)			Policy Number
Employer's /Association Address Number & Street		City & State	Zip Code
Date Hired	Job Title		
Employee's/Member's Name		Social Security Number	Height Weight
Employee's/Member's Address Number & Street		City, State, Zip	Monthly Income
Date of Birth	Place of Birth (City/State/Country)		<input type="checkbox"/> Male <input type="checkbox"/> Female
Employee's/Member's Telephone Number		( ) -	( ) -
		Work	Home

**PLEASE COMPLETE THIS SECTION ONLY IF YOU ARE APPLYING FOR LIFE INSURANCE.**

**The Amount Sections Must Be Completed**

NAME OF ALL LIFE APPLICANTS	RELATIONSHIP	SOCIAL SECURITY NUMBER	CURRENT LIFE AMOUNT	NEW TOTAL AMOUNT	DATE OF BIRTH	HEIGHT	WEIGHT
	Employee/Member		\$	\$			
	Spouse		\$	\$			
	Child		\$	\$			
	Child		\$	\$			
	Child		\$	\$			

**Medical Information:** Check "Yes" or "No" to each of the following questions. For any "Yes" answer, provide complete details on reverse side, including the condition, date(s) of treatment, diagnosis, and the Attending Physician's Name, City and State. If additional space is needed, please attach the medical information on a separate sheet of paper.

1. Name and address of my personal physician: \_\_\_\_\_ Date of and reason for my last consultation: \_\_\_\_\_  
 If none, check none.
2. Within the past 10 years have you or any applicant ever been treated or diagnosed by a member of the medical profession for any of the following:
  - A. High blood pressure, heart disease, heart murmur, or any other disorder of the heart or circulatory system?  Yes  No
  - B. Chronic fatigue, dizziness, fainting, convulsions, paralysis or stroke?  Yes  No
  - C. Cancer, diabetes, anemia or other disorder of the blood or endocrine system?  Yes  No
  - D. Asthma, emphysema, tuberculosis or other lung disorder?  Yes  No
  - E. Any sexually transmitted diseases?  Yes  No
3. Have you or any applicant ever been diagnosed or tested positive by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or \*Aids Related Complex (ARC)?  Yes  No
4. Within the past 5 years, have you or any applicant been treated or diagnosed for any of the following:
  - A. Intestinal bleeding, ulcer, hernia, colitis, diverticulitis or other disorder of the stomach, intestines, liver, kidneys, gallbladder, urinary tract or reproductive organs?  Yes  No
  - B. Arthritis, a strained or injured back, a slipped disc, scoliosis or any bone, joint or muscle disorder?  Yes  No
5. Other than above, have you or any applicant, within the last 5 years, been treated for any physical, mental or emotional condition, injury or sickness?  Yes  No
6. Within the past 10 years have you or any applicant: (a) been advised to seek or received counseling or treatment for the use of alcohol? (b) been advised to seek treatment, received treatment, or been arrested for the possession of or use of non-prescribed drugs? (c) used narcotics, cocaine, heroin, hallucinogens, barbiturates, or other habit forming drugs?  Yes  No
7. Have you or any applicant ever been declined for any type of insurance coverage, either for a new policy or a reinstatement?  Yes  No
8. Are you or any applicant now pregnant?  Yes  No
9. Are you or any applicant taking any medicine? If so, please list them (on reverse side).  Yes  No

\* Aids Related Complex (ARC) is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause.

**DETACH AND KEEP**

**STATEMENT CONCERNING AN INVESTIGATIVE CONSUMER REPORT**

This is to inform you that as part of our procedure for processing your insurance application an investigative consumer report may be prepared where by information is obtained through personal interview with your neighbors, friends or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this information.

**DISCLOSURE NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Provident Life and Accident Insurance Company, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates as 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 such 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.

Provident Life and Accident Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**SEE REVERSE SIDE – IMPORTANT**

**Give details of any "yes" answer from Health Section.**

<b>D E T A I L  S E C T I O N</b>	Question Number	Patient Name	Name of Ailment	Date	Details or Reason	Duration	Name, Address and Phone No. of Attending Physician and Hospital

**CURRENT COVERAGE SECTION**  
(If none, check "None")  None

Name of Company	Type of Coverage	Amount of Monthly LTD and/or Disability Income In Force	Year Issued	Do you plan to replace this coverage?	
				Yes	No

**PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY  
EMPLOYEE BENEFIT NOTICE OF INFORMATION PRACTICES**

This description of the Information Practices of Provident Life and Accident Insurance Company is being provided in accordance with the requirements of the Insurance Information and Privacy Protection Law.

To consider the insurance coverage applied for, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you and some may come from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

You have a right of access and correction with respect to the information collected about you except information which related to a claim or civil or criminal proceeding.

If you wish to have a more detailed explanation of our information practices, please furnish your full name, date of birth, address, the name of the group policyholder, and direct your written request to Health Underwriting Services, Employee Benefits, Provident Life and Accident Insurance Company,

**AUTHORIZATION TO OBTAIN INFORMATION**

I AUTHORIZE any physician, medical professional, hospital, clinic, other medical care institution, insurance or reinsuring company, the Medical Information Bureau, Inc., insurance support organization, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependent children as well as nonmedical information relating to me or my dependent children to give any such and all information to Provident Life and Accident Insurance Company or its reinsurers to assist in the evaluation of my application. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to outside third parties or any consumer reporting agency acting on Provident Life and Accident Insurance Company's behalf. Please provide any and all such information on myself and the following child(ren):

**List Name(s) of Eligible Dependent Child(ren):**

\_\_\_\_\_

\_\_\_\_\_

This authorization includes information about drugs and alcoholism.

I UNDERSTAND the information obtained by use of the Authorization will be used by Provident Life and Accident Insurance Company to determine eligibility for insurance.

I KNOW that I am entitled to receive a copy of the Authorization upon request.

I ACKNOWLEDGE receipt of the Notice of Information Practices.

I KNOW that I may request to be interviewed if an investigative consumer report is prepared in connection with this application.

I AGREE this authorization shall be valid for two and one-half years from the date shown below.

I AGREE that a photographic copy shall be as valid as the original.

To the best of my knowledge and belief, the above answers are true and complete. I understand that my answers form the basis of any coverage issued.

\_\_\_\_\_  
Signature of Employee/Member  
or Parent if Applicant is a minor. Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Spouse Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Child if age 18 or over Date \_\_\_\_\_

**Following Statement required by Florida and Oklahoma Insurance Departments:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.