UNUMPROVIDENT

Provident Life and Accident Insurance Company
1 Fountain Square, Chattanooga, TN 37402

GROUP CUSTOMER SERVICES

For Internal Use Only
Date Received (mm/dd/yyyy):

Member Number	OCC Code

Received/Recorded Date (mm/dd/yyyy)

❑ New Employee	❑ Previously Ineligible. Eligible Date. (mm/dd/yyyy)	❑ Rehired Employee. Date Rehired. (mm/dd/yyyy)	❑ Part-time to Full-Time. Date Effective. (mm/dd/yyyy)	❑ Change of status

Entity No.	Loc	Class	Employer Name and Address

Employee Name: (leave space between Last, First, MI)

No. of hours _____ Worked per Week	❑ Male ❑ Female	❑ Married ❑ Single # Children _____	Social Security No.	Date Hired Full Time (mm/dd/yyyy)	Date of Birth (mm/dd/yyyy)

Basic earnings: (Refer to your Plan Administrator for proper earnings definition.)
$ _____ + $_____ + $ _____ = $ _____
Base earnings Commissions (if applicable) Bonus (if applicable) Total earnings

❑ Hourly ❑ Weekly ❑ Bi-weekly
❑ Monthly ❑ Semi-monthly ❑ Annually
❑ Salaried/Exempt ❑ Hourly/Non-exempt ❑ Commissioned

Occupation: (List job title and major responsibilities)	State you live in	Zip Code

If applying for Voluntary Term Life, have you used any type of tobacco in the past 12 months? ❑ **Yes** ❑ **No**

EMPLOYEE COVERAGE REQUESTED **Select or refuse only the coverage(s) included in your Employer's policy.**

		Request	Refuse			Request	Refuse
Employee Basic Life	$	❑	❑	Voluntary AD&D	$	❑	❑
Employee AD&D	$	❑	❑	Voluntary Term Life	$	❑	❑
Basic Dependent Life:	$	❑	❑	Voluntary LTD	$	❑	❑
❑ Spouse ❑ Dependent ❑ Both		❑	❑	Other: (please be specific)		❑	❑
Long Term Disability (LTD)	$	❑	❑	❑		❑	❑
Short Term Disability (STD)	$	❑	❑	❑		❑	❑
Employee Supplemental Life	$	❑	❑	❑		❑	❑
Dependent Supplemental Life	$	❑	❑	❑		❑	❑

BENEFICIARY DESIGNATION

❑ Primary First MI Last Equally or survivor(s), if any.	Relationship	Date of Birth (mm/dd/yyyy)
Beneficiary address (Number, Street, City, State, Zip Code) Required for Florida and Virginia Residents	Social Security No.	
❑ Primary ❑ Contingent First MI Last Equally or survivor(s), if any.	Relationship	Date of Birth (mm/dd/yyyy)
Beneficiary address (Number, Street, City, State, Zip Code) Required for Florida and Virginia Residents	Social Security No.	

REQUEST FOR CHANGE

❑ 1. Please add dependents to my group insurance coverage. Reason: ❑ Marriage ❑ Birth of son/daughter ❑ Other (Explain)	Date I acquired eligible dependents (mm/dd/yyyy)	
❑ 2. Please change my beneficiary to: (First, MI, Last) Equally or survivor(s), if any.	Relationship	Date of Birth (mm/dd/yyyy)
Beneficiary address (Number, Street, City, State, Zip Code) Required for FL and VA Residents	Soc. Sec. No.	Witnessed:

❑ 3. Please change my name From: To:

I have read and understand the information in the employee booklets that have been provided to me by my employer relating to exclusions, benefit amounts, delayed effective dates and benefit offsets. I hereby request or refuse coverage under the group insurance policy issued by the Provident Life and Accident Insurance Company (UnumProvident). I understand that if I request coverage under the group policy, coverage will not go into effect unless I am actively at work on or after the proposed effective date of coverage. I hereby authorize my employer to deduct from my wages or salary the amount of contributions, if any, required for all coverages requested. I further understand that if I refuse any coverage under the group policy, I may apply at a later date and I must submit evidence of insurability. Such coverage will become effective on the date evidence of insurability is approved by UnumProvident.

_____ Date _____ (mm/dd/yyyy)
Signature of employee

Original—UnumProvident Home Office / Copy—Employer