

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
Home Address Date of Birth State of Birth
City - State - Zip Code Occupation Height 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 (Aids Related Complex)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you now receiving treatment or taking medication of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |

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 an eligible Employee and 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 an eligible Employee and 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 authorize the State Group Insurance Plan to release to Unum on behalf of myself and all family members information (name, address, social security number, age, gender, salary, enrollment effective/termination dates) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The State Group Insurance Plan will not condition treatment, payment, or enrollment eligibility on the signature of this authorization and may not have the right to control further disclosures of this information.

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; or (4) 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 Employee _____ Date _____
M-95202 (09/10)

NOTICE OF INFORMATION PRACTICES (Including 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. 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 New Business (2W), P.O. Box 190002, Chattanooga, Tennessee 37401-7210.