

**SIMPLIFIED ISSUE APPLICATION
FOR
VOLUNTARY DISABILITY INCOME INSURANCE**

- New Policy
- Additional Policy [Increase Monthly Benefit]
- Internal Policy Replacement
- Change to Existing Policy

Please Print

Section A: EMPLOYEE (Applicant Information)						
1. Name (First) (Middle) (Last) (Herein called You)					2. Social Security No.	
3. Residence Address (Street/Box No.)			(City)	(State)	(Zip)	
4. Birthdate	4a. State of Birth	5. Age	6. Sex <input type="checkbox"/> F <input type="checkbox"/> M		7. Home Phone Number	
8. Employer's Name		9. Employment Date	10. Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		11. Employee/Payroll No.	
12. Occupation			13. Hours worked per Week		14. Monthly Salary \$	

Section B: POLICY INFORMATION		
15. Risk Class: _____		
16. Elimination Period for Accidents: _____ Days		
17. Elimination Period for Sickness: _____ Days		
18. Benefit Period for Accidents and Sickness: _____ Months		
19. Coverage Selected	Monthly Benefit	Premium
Sickness and Off Job Accidents	\$ _____	\$ _____
<input type="checkbox"/> On Job Accidents	\$ _____	\$ _____
<input type="checkbox"/> Other	\$ _____	\$ _____
20. Total Premium Amount:		\$ _____
21. Payroll Premium Deducted:		
<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		
TOTAL PAYROLL PREMIUM:		\$ _____
Have you received an Outline of Coverage form? <input type="checkbox"/> Yes <input type="checkbox"/> No		
22. Will coverage applied for replace or modify any disability insurance? If "yes," provide details below and complete and submit required replacement forms if needed. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Insurance Company	Monthly Benefit	Policy Number
23. Do you have any group (excluding employer paid) or individual disability insurance now in force with us or any other company that <u>will not</u> be replaced or modified? If "yes," give details below. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Insurance Company	Monthly Benefit	Elimination/Benefit Period

Section C: MODIFIED ISSUE (Complete as required in addition to previous questions)

24. Have you ever tested positive for the HIV virus or its antibodies, or been diagnosed with or received treatment for acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? Yes No
25. In the past 12 months, other than colds, flu or normal pregnancy, have you taken time off from work or taken vacation for 5 or more consecutive days due to an accident, sickness, back, knee, neck, shoulder, joint or muscular disorder? Yes No
26. In the past 12 months have you received medical advice, sought treatment, including medication, or been hospitalized for any of the following: Yes No
- Heart Attack/Heart Surgery
 - Congestive Heart Failure
 - Stroke/Transient Ischemic Attack (TIA)
 - High Blood Pressure treated with 3 or more medications
 - Insulin Dependent Diabetes
 - Cancer (except basal cell skin cancer)
 - Hepatitis B&C
 - Cirrhosis

Section D: SIMPLIFIED ISSUE (Complete as required, in addition to Section C)

27. Height _____ ft. _____ in. Weight _____ lbs.
28. In the past 5 years have you received medical advice or sought treatment, including medication, for any of the following: Yes No
- Heart Attack/Heart Surgery
 - Congestive Heart Failure
 - Stroke/Transient Ischemic Attack (TIA)
 - Cancer (except basal cell skin cancer)
 - End Stage Renal/Kidney Disease
 - Chronic Obstructive Pulmonary Disease/Emphysema
 - Liver Disease/Hepatitis B&C/Cirrhosis
 - Neurological Disorder/Multiple Sclerosis
 - Chronic Fatigue Syndrome
 - Fibromyalgia
29. In the past 5 years have you received medical advice or sought treatment, including medication, for any of the following: (If "yes," give full details below.) Yes No
- Back Injury or Illness
 - Knee Injury or Illness
 - Neck Injury or Illness
 - Joint Injury or Illness
 - Muscular Injury or Illness
 - Carpal Tunnel Syndrome
 - Diabetes
 - Blood Pressure Reading of 140/90 or above
30. In the past 5 years have you had any medical disorders not previously disclosed during the application process to include diagnostic testing? If "yes," give full details below. Yes No
31. Are you currently taking any prescribed medication? If "yes," give full details below..... Yes No

Condition	Medication	Date of Onset	Doctor/Hospital	Type Treatment	Date of Recovery

Employee Name: _____ Employee SSN: _____
(Applicant) (Applicant)

EMPLOYEE (APPLICANT) STATEMENTS

I understand that coverage issued is based on all statements and answers recorded above. These statements and answers are complete and true. I understand that as the undersigned, I am the owner of any coverage issued under this application.

I understand the Coverage Effective Date of insurance as shown in the Policy Schedule is subject to the application being acceptable under Provident's rules, limits and standards and the insurance is, or would have been issued as applied for (or if not issued as applied for, then as modified). The Coverage Effective Date will be no earlier than the application signed date and no later than the date payroll deductions begin or premiums are collected for non-payroll deducted policies.

I have received the MIB, Inc. PreNotice. I hereby authorize any of the following who have any records or knowledge of me or my health to give such to Provident or its reinsurer(s): (a) licensed physician; (b) medical practitioner; (c) hospital, clinic, or medical or medically related facility; (d) insurance company; (e) employer; (f) the MIB, Inc.; or (g) organization, institution or person. This authorization includes any information relating to use of drugs or alcohol or my mental and physical history, condition, advice or treatment.

I also authorize all said sources (except MIB, Inc.) to give such records or knowledge to any agency contracted by Provident to collect and transmit such data. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for 30 months from the date shown below.

I authorize my employer to deduct the premiums for this insurance from my earnings (unless I have completed additional forms for a non-payroll method).

Dated _____ at _____
(Month/Day/Year) (City, State)

If this box is checked, a PIN # secured enrollment has authorized the application and a signature is not required.

Employee (Applicant) Signature

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.

AGENT STATEMENTS: (1) Do you have knowledge or reason to believe that the proposed insurance is intended to replace any existing insurance or annuities? Yes No (2) To the best of your knowledge and belief, the above statements and answers are complete and true.

Dated _____
(Month/Day/Year)

Agent's License No. _____

Printed Name of Agent _____

Licensed Agent's Signature

Policy Number: _____

**DETACH AND LEAVE WITH PROPOSED INSURED
DISCLOSURE NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Provident Life and Accident Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit 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 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 procedure 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 (617) 426-3660.

Provident Life and Accident Insurance Company or its reinsurer(s) 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.

**DETACH AND LEAVE WITH PROPOSED INSURED
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 information is obtained through personal interviews 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. No inquiry shall be made which is directed toward determining your sexual orientation. 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.