

# Application to Provident Life & Accident for Additional Group Life Insurance Plan\*

Supplemental Life     Supplemental Plus

**PART**

**A**

**4936LD**

policy number                      code                      C/D

SOC. SEC. NUMBER

office use only

applicant print last name                      first                      middle initial                      sex  M  F                      month                      day                      year of birth

home street address                      city                      state                      zip code

name of employing school district                      name of school or unit

month                      day                      year first employed                      full name of beneficiary (example: Mary Ann Smith, not Mrs. John Smith)

relationship of beneficiary                      address of beneficiary if not a member of immediate family  
 YES     NO    Are you currently insured for Basic Coverage?                      Your Basic Plan number (1, 2, 3, 4, 5, 6, 7, 8.)  
 YES     NO    Are you actively employed as of this date?                      (Circle appropriate number.)

I hereby authorize my employer to deduct from my salary such amounts as may now or hereafter be payable by me and to forward this amount to Provident Life & Accident for Group Life Insurance coverage in accordance with Rate Schedule of the Master Policy. I also reserve the right to revoke this authorization by giving written notice prior to the next premium due date.

**Payroll Deduction**

\$ \_\_\_\_\_  
 monthly     tenths  
**Signature of Applicant**                      **Date**                      **Social Security Number**  
 For Official Use Only

GMR-5A-2-88                      **Supplemental**                      eff date                      mos                      class                      fee    e    fee    d                      msg                      msg

The following representations shall form a basis for the insurance company's approval or rejection of this application. Each question must be answered individually.

My height is \_\_\_\_\_ Ft.                      In.                      My weight is \_\_\_\_\_ lbs                      My date of birth \_\_\_\_\_                      My place of birth \_\_\_\_\_

- PART 1. B**
1. To the best of your knowledge have you ever had or been told you had
- a. High Blood Pressure                      Yes    No
  - b. Heart Disease
  - c. Cancer or Malignancy
  - d. Diabetes
  - e. Kidney Disease
  - f. Ulcer
  - g. Tuberculosis
  - h. Brain Disease or Mental Disorder
2. During the past five years
- a. Had any injury or illness not indicated above?                      Yes    No
  - b. Received medical treatment or advice for injury or illness or been hospitalized or had surgery?
3. Within the past two years, have you used LSD, Marijuana or other similar agents?                      Yes    No                          

4. Have you ever had a physical check-up, consulted, been treated or examined by any physician or practitioner during the past five years for any reason not mentioned previously?                      Yes    No                          

5. Have you ever had a physical check-up, consulted, been treated or examined by any physician or practitioner during the past five years for any reason not mentioned previously?                      Yes    No                          

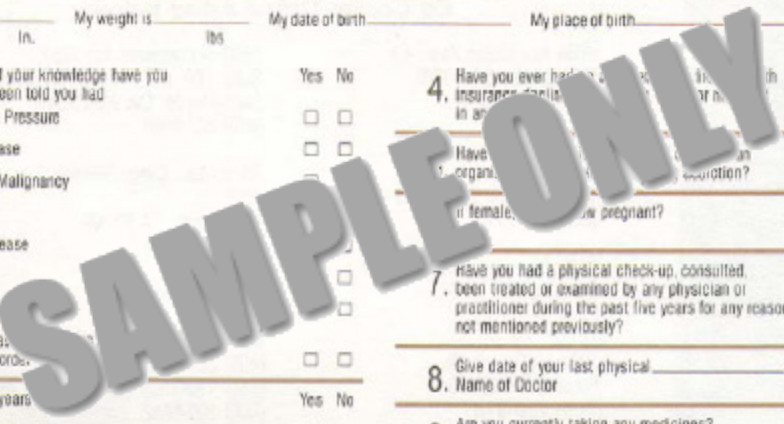
6. Have you ever had a physical check-up, consulted, been treated or examined by any physician or practitioner during the past five years for any reason not mentioned previously?                      Yes    No                          

7. Have you ever had a physical check-up, consulted, been treated or examined by any physician or practitioner during the past five years for any reason not mentioned previously?                      Yes    No                          

8. Give date of your last physical \_\_\_\_\_  
 Name of Doctor \_\_\_\_\_

9. Are you currently taking any medicines?                      Yes    No                          

If yes, please list below \_\_\_\_\_



**BELOW, GIVE DETAILS OF ALL "YES" answers. Include all dates, diagnoses, duration, outcome, and names and addresses of all attending physicians.**

(Use additional paper, if necessary—but please staple it to this side, or mail it with these forms in a sealed envelope to the address on back. Please use postage stamp on envelope.)

I represent that to the best of my knowledge all statements and answers recorded on this application are true and complete. I agree that this application shall be a part of any insurance granted upon it under Group Policy #4936 LD, issued by Provident Life & Accident Insurance Company.

**Underwriting Authorization to Obtain Information**  
 I authorize any physician, medical professional, hospital, clinic, other medical care institution, Medical Information Bureau, insurer, consumer reporting agency, or employer having information available as to other insurance coverage, medical care, advice, treatment or supplies with respect to any physical or mental condition, or other personal information regarding me to give the information to Provident Life & Accident or any consumer reporting agency acting on Provident's behalf.  
 I understand that this information will be used by Provident to determine eligibility for insurance.  
 I agree this authorization is valid for two and one half years from the date shown below.  
 I know that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.  
 I have received and read the Notice of Insurance Information Practices and Notice of Disclosure of Information in the brochure, which was attached.