Provident Life and Accident Insurance Company
1 Fountain Square
Chattanooga, Tennessee 37402-1338

GUARANTEED STANDARD APPLICATION

I hereby apply for insurance based on the following representations to Provident Life and Accident Insurance Company (herein referred to as The Company).

PERSONAL INFORMATION

Proposed Insured: (herein referred to as "You," "Your," "I," "Me" or "My")

1.(a) Name: (Last, First, Middle) Professional Designation | **(b)** Sex: ❑ M ❑ F | **(c)** Date of Birth: (Mo/Day/Yr)

(d) Birthplace: (State/Country) Not Applicable
(e) Are you a U.S. Citizen ❑ Yes ❑ No **(f)** If "no," what country? N/A
(g) If No, do you have a Green Card? ❑ Yes ❑ No

(h) Length of U.S. Residence Not Applicable
(i) Social Security Number:
(j) Employee ID Number: N/A

(k) Residence Address: (Street/Apt No./P.O. Box No., City, State, Zip) c/o RX Financial Resources, 340 W. Butterfield Rd. Ste LE Elmhurst, IL 60126
(l) Res Phone: N/A

(m) Business Address: (Street/Apt No./P.O. Box No., City, State, Zip) c/o RX Financial Resources, 340 W. Butterfield Rd. Ste LE Elmhurst, IL 60126
(n) Bus Phone: N/A

2.(a) Employer: Northwestern University Feinberg School of Medicine
(b) Occupation: Medical Student
(c) Annual Earned Income: Not Applicable

(d) Date of hire: Not Applicable (Mo/Day/Year)
(e) Number of hours worked per week: N/A hours

		YES NO
3.	For the period of time commencing 180 days prior to, and including, the date of this application:	
(a)	Have You missed 1 or more days of work, or been homebound or admitted to a medical facility, due to injury or sickness?	❑N/A❑
(b)	Have You had any restrictions or limitations to your ability to work on a full time basis due to injury or sickness? If the answer to (a) or (b) above is "yes," please provide details Not Applicable	❑N/A❑
4.	Have You used tobacco in the past 12 months? (*Tobacco means cigarettes, cigars, snuff/dip/chew, pipe or Nicotine Delivery Systems)*	❑N/A❑
5.	Do You need human assistance of any kind to perform everyday activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from the chair to Your bed), or do You have any memory loss or confusion?	❑N/A❑
6.	Do You use any medical equipment or appliances such as a cane, wheelchair, catheter, oxygen tank, pacemaker or artificial limb?	❑N/A❑
7.	Have You ever been diagnosed or treated for blindness or deafness, or the loss of use of both arms, both legs, or one arm and/or one leg or any other amputation, or any speech defect?	❑N/A❑

EXISTING AND/OR PENDING INSURANCE COVERAGE

1. Is the insurance to be issued intended to replace any accident and sickness insurance? Not Applicable ❑ Yes* ❑ No
2. Other than Group LTD and this offer of coverage, do You have or are You applying for other disability coverage: (A) Individual (D) LTD Not Applicable ❑ Yes ❑ No

(If "Yes," give details below)

Name of Insurance Company(s) (including Provident/Unum/Paul Revere)	Type of Coverage (Use code above)	Monthly Face Amount Base	SIS	Elimination Period	Benefit Period	Indicate if coverage will be changed or replaced*	Effective date of discontinuance	Paid by employer? Yes	No
								❑	❑
								❑	❑
								❑	❑

Please complete and submit state required replacement forms if needed.

DECLARATION, AGREEMENT AND AUTHORIZATION

I agree with the following statements:

1. The statements and answers in this application are true and complete and correctly recorded. I understand that they will become part of My application and any policies issued on it. If My answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind My coverage.
2. No broker has authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.
3. The insurance applied for will take effect if one of the following conditions occur:
   a. If the employer is paying the premium, immediately upon the date You fully complete and sign Your application provided You qualify for coverage under the terms and conditions of the offer; or
   b. If You are paying the premium, the first of the month in which premiums are deducted after approval of Your application.
   The only exceptions to this are provided in the written agreement between the Company and employer as payor of policy or payroll deduction administrator.
4. I have received a copy of the Notice of Information Practices (including Medical Information Bureau Notice and Fair Credit Reporting Act Notice).
5. I HAVE BEEN INFORMED that any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be prosecuted for insurance fraud.

Disclosure Authorization

I AUTHORIZE: any doctor, hospital, clinic, provider of health care, insurance (or reinsuring) company, Medical Information Bureau Group, Inc., My insurance agents, employers or any other person or firm having: (i) information as to cause, treatment, diagnosis, prognosis or advice of My physical or mental condition; or (ii) any other information needed to determine My eligibility for insurance; to give Unum and its affiliates and its employees and agents or My broker, all such information. This may include (but is not limited to) information about mental illness, and use of alcohol or drugs. I authorize Unum to give MIB Group, Inc. a report of this information. A photocopy of this authorization is valid. I or My authorized representative may request a copy of this authorization. This authorization will be in force for two years and six months from the date shown below.

(X) ____IL____
State of Application

(X) ________________
Dated

(X)____RX Financial Resources____
Licensed Broker

(X) ________________
Signature of Proposed Insured

THIS DECLARATION, AGREEMENT AND AUTHORIZATION MUST BE PROPERLY SIGNED, INCLUDING PROPOSED INSURED'S SIGNATURE, BEFORE APPLICATION CAN BE PROCESSED

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