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).

SECTION 1: PERSONAL INFORMATION — Always Complete

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: (mm/dd/yyyy)

(d) Social Security Number | **(e)** Employee ID Number
Student ID#:

(f) Birthplace: (State/Country)
N/A

(g) Are you a U.S. Citizen? ☐Yes **N/A** ☐ No **(h)** If "no," what country? **N/A**
(i) If No, do you have a Green Card? **N/A** ☐ Yes ☐ No
(j) If No, do you have a Visa? ☐ Yes ☐ No What type of Visa? **N/A**

(k) Residence Address: Street/Apt No./P.O. Box No City State Zip **(l)** Res Phone: **N/A**
c/o KME Insurance Brokerage, 2650 Warrenville Rd, Ste 100, Downers Grove, IL 60515

(m) Business Address: Street/Apt No./P.O. Box No City State Zip **(n)** Bus Phone: **N/A**
c/o KME Insurance Brokerage, 2650 Warrenville Rd, Ste 100, Downers Grove, IL 60515

(o) Preferred E-mail address at which to be contacted: **N/A**

2. **(a)** Employer:
Northwestern University Feinberg School of Medicine

(b) Occupation(s) and Title(s):
Medical Student

(c) Annual Earned Income:
NA

(d) Date of hire: (mm/dd/yyyy)
NA

3. Number of hours worked per week: _____NA____ hours

4. For the period of time commencing 180 days prior to, and including, the date of the of this application:	**YES**		**NO**
(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?	☐	**N/A**	☐
(c) As of the date this application is signed, are you working on a full time basis without restrictions or limitations due to injury or sickness?	☐	**N/A**	☐

Please provide details including number of days missed, dates and details of restrictions or limitations _____NA_____

5. Have You used tobacco in the past 12 months? *(Tobacco means cigarettes, cigars, snuff/dip/chew, pipe or Nicotine Delivery Systems)*	☐	**N/A**	☐
6. 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**	☐
7. Do You use any medical equipment or appliances such as a cane, wheelchair, catheter, oxygen tank, pacemaker or artificial limb?	☐	**N/A**	☐
8. 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**	☐

SECTION 2: EXISTING AND/OR PENDING INSURANCE COVERAGE — Always Complete

1. Do You have any Group Long Term Disability coverage, in force or being applied for? ..... ☐ Yes **N/A** ☐ No
If yes, what is the monthly benefit amount? _____
Is this coverage Employer pay? ..... ☐ Yes **N/A** ☐ No

2. Do You have any Individual Disability coverage, in force or being applied for? ..... ☐ Yes **N/A** ☐ No
(If "Yes", complete the following)

Company Name	Monthly Benefit	Is coverage paid by the employer?	Is insurance being applied for replacing this coverage?*	If yes, replacement date?
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	

Please complete and submit state required replacement forms if needed.

SECTION 3: Complete when applying for Serious Illness Benefit

DO NOT COMPLETE SECTION 3

In the past 10 years, have You:	YES	NO
1. Been diagnosed with or sought medical treatment (including medication) for heart attack, coronary disease, stroke or transient ischemic attack, organ transplant, renal (kidney) disease or failure, hepatitis B or C, cirrhosis, emphysema, chronic obstructive pulmonary disorder or diabetes (excluding gestational diabetes)?	☐	☐
2. Been prescribed three or more medications to be taken concurrently for high blood pressure?	☐	☐
3. Been diagnosed with or sought medical treatment (including medication) for: cancer including Leukemia, Hodgkin's Disease, skin cancer (excluding basal cell cancer) or malignant tumors of any kind?	☐	☐

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. (If the application is fully completed and signed after the first of the month in which deductions begin, coverage will be effective on the date of the application.)
   The only exceptions to this are provided in the written agreement between the Company and the 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 additional information required by the Fair Credit Reporting Act).
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 24 months from the date shown below.

(X) IL
State of Application

(X)
Dated

(X) KME Insurance Brokerage
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