PROVIDENT

VOLUNTARY TERM LIFE ENROLLMENT FORM

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

GENERAL INFORMATION

Employer Name: *(Please Print)*		Policy Number:		
Employee Name:	O Female O Male	Social Security Number / /		Date of Birth / /
Spouse Name:	O Female O Male	Social Security Number / /		Date of Birth / /
Street Address: City/State/Zip:	Home Phone ( )	Work Phone ( )		
Employee Occupation (Specific Duties):	Hire Date:	Earnings $	O Weekly O Monthly O Hourly O Yearly	Hours per week

VOLUNTARY TERM LIFE - GUARANTEED ISSUE AMOUNTS ONLY

HAS EMPLOYEE USED ANY TYPE OF TOBACCO IN THE PAST 12 MONTHS? O Yes O No

PREMIUM FREQUENCY: O Weekly O Bi-weekly O Semi-monthly O Monthly O Other _____

O Optional AD&D (Coverage equal to Base Life Amount) - If elected, employee and dependents must be covered.

	Face Amount	Life Premium	AD&D Premium	Total Premium
O Employee Insurance Amount	$	$	$	$
O Spouse Insurance Amount	$	$	$	$
O Dependent Child Benefit	$	$	$	$
*Spouse rate based on Employee age and tobacco-use status.			**Total VTL Premium**	**$**

COMPLETE FOR DEPENDENT CHILDREN'S INSURANCE	Child's Name (First) (Middle) (Last)	Social Security Number	Date of Birth Mo. Day Yr.	Issue Age	Sex M or F	Relationship to Employee

Name of Beneficiary and Relationship to Employee (Beneficiary for spouse and child(ren) coverage is Employee):

Primary Beneficiary: Name	Relationship	Date of Birth	**Contingent** Beneficiary: Name	Relationship	Date of Birth

REQUEST FOR COVERAGE

The Voluntary Benefit Program has been offered to me and after seriously considering the benefit, I have decided to: (Please indicate your choice)

O Request the coverage for which I am or may become eligible under the group policy issued by Provident Life and Accident Insurance Company. I also:
(1) authorize any required deductions from my earnings;
(2) name the beneficiary on this Enrollment Form to receive any benefits payable in the event of my death; and
(3) understand that to be eligible I must currently be actively at work and performing my normal duties of a person of like age.

O Not to enroll myself or dependents in the Program.

Please review the Authorization and sign below.

THE AUTHORIZATION BELOW MUST BE SIGNED AND DATED OR THE ENROLLMENT FORM WILL BE RETURNED

Dated at _____ this _____ day of _____

Signature of Agent: _____ Agent Code: _____ Signature of Employee: _____

Signature of Spouse (if proposed for insurance): _____