

PROVIDENT AMERICAN INSURANCE COMPANY

10501 N. Central Expressway • Dallas, Texas • 75231-2200

Application for: Supplemental Accident Expense Policy

Requested Effective/Draft Date _____

PART I - GENERAL INFORMATION

1. PERSONS TO BE COVERED

Name (Please PRINT Full Name)	Relationship	Sex	Date of Birth	Age	Height Ft. In.	Weight Lbs.	Social Security Number
1.							
2.							
3.							N/A
4.							N/A
5.							N/A

2. APPLICANT'S HOME ADDRESS

Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: (_____) _____

3. PREMIUM PAYOR ADDRESS (If different than Applicant)

Premium Payor Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: (_____) _____

4. EMPLOYMENT INFORMATION (All adult applicants)

Employer's Name: _____
 Occupation/Duties: _____
 Spouse's Employer's Name (if applying): _____
 Spouse's Occupation/Duties: _____

5. BENEFIT INFORMATION

Benefit Amount: 1 Unit 2 Units
 Plan Type: Individual Individual & Spouse Single Parent
 Family Child(ren) Only
 Billing Method: Bank Draft Direct Bill List Bill
 Billing Mode: Monthly Quarterly Semi-Annual Annual

6. OPTIONAL RIDER

Accident Disability Income Benefit Rider 1 Unit 2 Units

7. BENEFICIARY

Name: _____
 Relationship: _____

8. PRIMARY PHYSICIAN

Name: _____
 Address: _____
 Phone: _____

PART II - REPRESENTATION & QUESTIONS OF THE APPLICANT

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are all persons to be insured to the best of your knowledge and belief in good health and free from physical impairment or abnormality? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is any person to be insured engaged in any hazardous sports or activities including racing, parachuting, rodeo riding, motorcycling or scuba diving? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is any person to be insured currently under treatment or has any person to be insured been under treatment for excessive drug or alcohol abuse in the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Will the insurance applied for replace or change any existing insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, give name of Company and type of insurance: _____ | | |
| 5. Is there any other health, accident or disability insurance in force on the proposed insured? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, give name of Company and type of insurance: _____ | | |

HOME OFFICE USE ONLY: Agent # _____ Policy # _____ Eff. Date _____ Initial Premium _____

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Provident American Insurance Company, Dallas, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

_____ X _____
Date Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ I hereby authorize _____
Name Name of Employer
to deduct from my salary and pay to Provident American Insurance Company, Dallas, Texas, the monthly deposits as set forth below. Beginning with the month of _____, \$ _____ each month.

_____ Date Signature of Employee

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

- A. I hereby authorize and request any physician, hospital, dentist, pharmacy, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Provident American Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in the circumstances permitted by 28 TAC § 21.704.
 - B. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer, the Medical Information Bureau, Inc. ("MIB") or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Provident American Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy.
 - C. Provident American Insurance Company or it's reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply.
 - D. This authorization will be valid from the date signed for a period of two and one half years.
 - E. I authorize Provident American Insurance Company to obtain an investigative consumer report on me.
- I have read or had read to me the completed application and my answers and statements are correct and true. I understand: 1) that my qualification for insurance is based upon my answers and statements; 2) that this form seeks full disclosure of the information sought and no one has the authority to alter or exclude or to direct me to exclude any qualifying information sought by this form; and 3) that a fraudulent act or intentional misrepresentation of a material fact may result in loss of coverage or claim denial.

I understand that coverage is not effective unless and until approved and issued by the Company.

Dated: _____ Dated at: _____
Signed X _____ Signed X _____
Signature of Proposed Insured Signature of Spouse (if applicable)

APPLICANT'S STATEMENT

- 1. I hereby apply to Provident American Insurance Company for a policy to be issued in reliance on my written answers to the foregoing questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an Outline of Coverage for the policy applied for.
- 2. 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 a false or deceptive statement is guilty of insurance fraud.
- 3. I understand that if the Accident Disability Income Benefit Rider is elected, the maximum benefit per month will not exceed 60% of my gross monthly income.

Dated at _____ on _____ 20____.
City, State & Zip Month & Day

Signature of Applicant: _____ Signature of Spouse: _____

AGENT'S STATEMENT

I Certify: 1) That any information recorded by me is true and correct to the best of my knowledge and belief. 2) I have given an outline of coverage for the policy applied for to the Applicant. 3) This (does) (does not) replace other insurance.

Dated at _____ on _____ 20____.
City, State & Zip Month & Day

_____ Agent Name (Print) Agent Signature Agent No.