

# PROVIDENT AMERICAN INSURANCE COMPANY

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

## APPLICATION FOR: VALUPROTECTOR

### HOME OFFICE USE ONLY

AGENT # \_\_\_\_\_

POLICY # \_\_\_\_\_

EFF. DATE \_\_\_\_\_

Special Draft Date Request: \_\_\_\_\_

### PRIMARY PROPOSED INSURED

1. Name (Please Print Full Name) \_\_\_\_\_ 2. Ht \_\_\_\_\_ Wt \_\_\_\_\_

3. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

4. Sex  M  F 5. Social Security Number \_\_\_\_\_ 6. Home Phone No. (\_\_\_\_\_) \_\_\_\_\_

7. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ 8. Birth Place (State or Country) \_\_\_\_\_ 9. Age \_\_\_\_\_

10. Drivers License # \_\_\_\_\_ 11. Occupation \_\_\_\_\_ 12. Employer \_\_\_\_\_

### 13. MONTHLY PREMIUM

\$22  \$32  \$42

Premium \_\_\_\_\_

### 14. PLAN ANDFACE AMOUNT

Plan \_\_\_\_\_

\$ \_\_\_\_\_

### 15. PREMIUM MODE

EFT Monthly  Quarterly  Semi-Annual

Annual  MonthlyDirect

### 16. BENEFICIARY

Full Name

Relationship

PRIMARY \_\_\_\_\_

CONTINGENT \_\_\_\_\_

### 17. EXISTING LIFE INSURANCE

Existing Life Insurance:  None

Is replacement of existing insurance involved in this application?  YES  NO

If YES, please provide company and face amount: \_\_\_\_\_

If YES: have you submitted the appropriate replacement forms?  YES  NO

### QUESTIONS

Please provide details to "YES" answers in Remarks Section (see back)

YES NO

18. Has any Proposed Insured within the past 5 years:
- a) been charged with a driving while impaired (alcohol, drug, other) violation, had a drivers license revoked or suspended or within the last 24 months received 3 or more citations for moving traffic violations? .....
  - b) had an application for insurance declined, rated, or postponed? .....
  - c) flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so? .....
  - d) engaged in parachuting, racing or other hazardous sport or intend to do so? .....
  - e) used intravenous drugs, cocaine, barbiturates, hallucinogens, sought advise or treatment for alcohol or drug use? .....
19. Does any proposed insured intend to travel or reside outside the U.S.? .....
20. Has any Proposed Insured ever had, or been told they had, or received treatment or advice for:
- a) abnormal blood pressure, coronary artery disease or any other disorder or disease of the heart, blood vessels or cardiovascular system? .
  - b) cancer, tumor, or any other growth or malignancy? .....
  - c) diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder? .....
  - d) any nose, throat, lung, or any other respiratory disorder? .....
  - e) any disorder of the stomach, intestines, rectum, liver, or pancreas? .....
  - f) any injury to or disease of the bones, muscles, joints, eyes, or skin? .....
  - g) epilepsy, seizures, brain disorder, or any other disease or disorder of the nervous system? .....
  - h) anxiety, depression, or an emotional, behavioral, mental or nervous disorder? .....
  - i) any disease or disorder of the kidney, bladder, or genital organs or system? .....
  - j) AIDS (acquired immune deficiency syndrome), positive HIV test, or any other immunological disorder? .....
21. Other than as stated above, has any Proposed Insured within the past 5 years:
- a) consulted, received treatment or advice from, been prescribed medication by any other medical advisor? .....
  - b) had any abnormal diagnostic tests? .....
  - c) been aware of any symptoms for which a medical advisor has not yet been consulted? .....
22. Has any of proposed insured's family members (parents, siblings) had heart disease, kidney disease, diabetes, cancer, stroke, or any other hereditary disease? .....
- If YES, indicate family member, illness, age at onset of illness and, if applicable, age at death.
23. Has Primary Proposed Insured used tobacco within the past 12 months? .....

VP.10.APP (5/99) (Rev. 7/00)

### NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Provident American Insurance Company, or its Reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member Company for life or health insurance coverage, or a claim for benefits is submitted to such a Company, the Bureau, upon request, will supply such Company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of and information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts, 02112, telephone (617) 426-3660.

Provident American Insurance Company, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**REMARKS (Explain "YES" answers to Questions 18-24)**

Name of Person(s)	Illness	Date & Duration	Treatment & Results	Doctors & Hospitals

**AGREEMENT - AUTHORIZATION - ACKNOWLEDGMENT**

I, the Primary Proposed Insured, by my signature set forth hereafter:

**AGREE** to the following:

(a) All Statements and answers in this application are complete and true to the best of my knowledge and belief. (b) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is delivered while the health of any proposed insured continues, without material change, to be as represented in this application. (c) No agent has authority to waive any answer or otherwise modify this application or to bind Provident American Insurance Company, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this application.

**AUTHORIZE** any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or any other organization, institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about HIV, drug, chemical, or alcohol abuse or any other non-health (non-medical) history information.

I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this Authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 30 months from the date shown below. I know that I or my representative may request a copy of this authorization.

**ACKNOWLEDGE** receipt of the following notices:

(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and (b) MIB Pre-Notice.

Signed at \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ X) \_\_\_\_\_  
City State Date Signature of Primary Proposed Insured (If Age 16 Or Over or Parent or Guardian (Juvenile Application))

\_\_\_\_\_  
Signature of Licensed Agent X) Name of Agent (Print) Agent Number X) Signature of Owner & Relationship (If Other Than Primary Proposed Insured)

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

**DISCLOSURE**

The acceleration-of-life-insurance benefits offered under the rider attached to your policy may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration-of-life-insurance benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law.

Receipt of acceleration-of-life-insurance benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

**"Covered" diseases and illnesses:** Heart attack, stroke, coronary bypass surgery, or life threatening cancer occurring anytime during the Insured's lifetime and while the policy is in force after 60 days from the policy's issue date is covered (see Accelerated Living Benefit Rider for complete details).

The Death Benefit amount will be reduced by any benefits paid under the Accelerated Living Benefit Rider.

**AUTHORIZATION TO MY BANK**

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks drawn on my account by and payable to the order of Provident American Insurance Company, 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 forfeiture of insurance.

\_\_\_\_\_ X) \_\_\_\_\_  
Date Signature (as it appears on bank records)

**IF BANK  
DRAFT  
ATTACH  
VOIDED CHECK  
HERE AND  
SIGN  
AUTHORIZATION**

**NOTICE OF INFORMATION PRACTICES**

**This Notice must be given to Proposed Insured**

(Including Medical Information Bureau Notice, Fair Credit Report Act of 1970, and Public Law 91-508)

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or otherwise with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.