



UnumProvident Corporation
 1 Fountain Square
 Chattanooga, Tennessee 37402-1338

INCOME PROTECTION ENROLLMENT APPLICATION

Please indicate the insuring company to which you are applying (together with UnumProvident Corporation, herein collectively referred to as "the Company"): Provident Life and Accident Insurance Company
 Unum Life Insurance Company of America
 I hereby apply for insurance based on the following representations: The Paul Revere Life Insurance Company

SECTION 1 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) _____ (e) Length of US Residence: _____ (f) Social Security Number: _____

Not Applicable **Not Applicable**

Street/Apt No./P.O. Box No. _____ City _____ State _____ Zip _____

(g) Residence: **c/o RX Financial Resources, 340 West Butterfield Rd, Ste LE, Elmhurst IL 60126** (h) Res Phone: **Not Applicable**

(i) Business: **Loyola University Chicago/Strich School of Medicine** (j) Bus Phone: **Not Applicable**

2.(a) Employer: **Loyola University Chicago/Strich School of Medicine** (b) Occupation: **Medical Student** (c) Earned Income: **Not Applicable**

(d) Date of hire: **Not Applicable** (Mo/Day/Year) _____ (e) Average number of hours worked per week: **NOT APPLICABLE**

3. For the period of time commencing 180 days prior to, and including, the date of this application: **YES NO**

(a) Have You been continuously at work on a full-time basis performing all the duties of Your occupation without limitation due to injury or sickness? **NOT APPLICABLE**

(b) Have You been homebound or hospitalized due to injury or sickness? **NOT APPLICABLE**

(c) How many days have You missed due to an injury or sickness? **NOT APPLICABLE** (Please provide details below)

Details for 3(a), (b), and (c) _____

SECTION 2 MEDICAL INFORMATION

If "Yes" response to Questions 1 through 4, please provide details such as diagnosis; dates or length of treatment; treating practitioners and addresses in the space provided below.

1. Have You used tobacco in the past 12 months? **NOT APPLICABLE** **YES NO**
 (Tobacco means cigarettes, cigars, snuff/dip/chew, pipe or Nicotine Delivery Systems)

2. Do You need human assistance of any kind to perform every day 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? **NOT APPLICABLE**

3. Do You use any special medical equipment or appliances such as a cane, wheelchair, catheter, oxygen tank, pacemaker or artificial limb? **NOT APPLICABLE**

4. Have You ever been diagnosed or treated for or had any known indication of blindness or deafness, or the loss of use of both arms, both legs, or one arm and one leg, or any speech defect? **NOT APPLICABLE**

Details for 1 through 4 _____

SECTION 3 EXISTING AND/OR PENDING INSURANCE COVERAGE

1. Is the insurance to be issued intended to replace any accident and sickness or life insurance? **NOT APPLICABLE**

2. Do You have, are You applying for, are You currently eligible for or will You become eligible within the next 12 months for other: **NOT APPLICABLE**

(A) Individual (C) Association (D) LTD 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		Elimination Period	Benefit Period	Indicate if coverage will be changed or replaced*	Effective date of discontinuance	Paid by employer?	
		Base	SIS					Yes	No
								<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>

* Please complete and submit state required replacement forms if needed and provide details below:

Additional Details: _____

SECTION 4 DECLARATION, AGREEMENT AND AUTHORIZATION

It is understood and agreed as follows:

1. I have read the statements and answers recorded above. They are true and complete and correctly recorded. They will become part of this Application and any policy(ies) issued on it.
2. I will permanently discontinue any group or individual policy(ies) shown to be discontinued in answer to question 2 in Section 3 on or before the date(s) indicated. The Company will rely on such answers in determining the amount of, if any, insurance it will issue. Benefits under any policy issued on this application may be reduced by the amount payable under such existing policies.
3. No broker has authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.
4. The Company has the right to require medical exams and tests to determine insurability.
5. The insurance applied for will not take effect unless the issuance and delivery of the policy and payment of the first premium occur while My health and any other person to be insured under the policy remains as stated in the Application. The only exceptions to this are provided in the Conditional Receipt or Payroll Deduction Authorization Form.
6. The Company is authorized to obtain an investigative consumer report on Me.
7. Acceptance by the Proposed Insured/Owner of any policy issued on this Application will ratify any changes made by amendments.
8. I have received a copy of the Notice of Information Practices (including Medical Information Bureau Notice and Fair Credit Reporting Act Notice).
9. If coverage applied for qualifies as a benefit under an employee welfare benefit plan established or maintained by the employer and governed by the Employee Retirement Income Security Act (ERISA), UnumProvident Corporation and its affiliates will be the claims administrator and have full, final, binding, and exclusive discretion to determine benefits. Pursuant to ERISA the policyholder will be entitled to appeal any claims decision.
10. I UNDERSTAND that if My answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind My coverage.
11. 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.

Chicago, IL

Signed at: City and State

Dated

(X) **RX Financial Resources**
Licensed Broker

(X) _____
Signature of Proposed Insured

Disclosure Authorization

I AUTHORIZE: any doctor, hospital, clinic, provider of health care, insurance (or reinsuring) company, consumer reporting agency, Medical Information Bureau 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 the UnumProvident Corporation and its affiliates and its employees and agents, My broker, or any consumer reporting agency, all such information. This may include (but is not limited to); information about driving records, mental illness, and use of alcohol or drugs.

I UNDERSTAND the information obtained with this authorization will be used by the Company to determine My eligibility for insurance. A photocopy of the 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) _____
Signature of Proposed Insured

Date

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

