Date___/___/____

NOTICE OF ADVERSE UNDERWRITING DECISION

We wish to thank you for your application for Insurance coverage with our Company. Since your application was denied or issued other than as applied for, upon written request you have the right to know the specific reasons for this action. In addition, you have the right to know specific items of information that support the action, the identity and address of any institutional source of that information and the right to see and copy, in person, or to obtain copies by mail of certain documents relating to this decision. You have the right to know the identity, if recorded, of those persons to whom we have disclosed personal information within two years prior to your request and if the identity is not recorded, the names of those insurance institutions, agents, insurance support organizations or other persons to whom the information is normally disclosed. This right does not extend to information if we have a reasonable suspicion that criminal activity, fraud, material misrepresentation or nondisclosure is involved.

Disclosure of medical records or examination information will be made to the specifically named physician of your choice upon your written request to do so. Information pertaining to an investigative report, if applicable, may be obtained from the appropriate Consumer Reporting Agency.

Some medical conditions, due to their delicate nature, shall be supplied directly to you, only with the approval of the qualified professional person with treatment responsibility for the condition to which the information relates.

If, after reviewing information about you in our files, you believe that it is incorrect, you may request in writing that we correct, amend or delete any item of personal information. Within thirty (30) business days of our receipt of your request, you will be notified if we can comply with your request. If we are unable to comply with your request, we will tell you why and allow you to file a statement of your disagreement. This statement will be sent to anyone to whom we have disclosed this information in the past two years, and in the future.

If we correct, amend or delete information about you in our files, we will notify any insurance support organization to which we have systematically sent such information within the preceding seven years unless the insurance support organization no longer maintains recorded personal information about you.

If you would like additional information concerning this action or your rights, please submit a written request to the Voluntary WorkPlace Benefits Underwriting Department at the address given within ninety (90) business days from the date above.

Thank you again for your interest in our Company and the opportunity to consider your application for coverage. We hope that the above information has been of assistance to you.

Voluntary WorkPlace Benefits - Underwriting (2-W)
Provident Life and Accident Insurance Company
1 Fountain Square
Chattanooga, TN 37402