

**APPLICATION  
FOR  
ACCIDENT INSURANCE**

**Applying For:**  
New Coverage   
Change of Coverage

<b>Section A: EMPLOYEE - Applicant Information (Always complete)</b>						
1. Name (First) (Middle) (Last)					2. Social Security No.	
3. Residence Address (Street / Box No.)			(City)		(State)	(Zip)
4. (a) Birthdate	4. (b) State of Birth	5. Age	6. Sex <input type="checkbox"/> F <input type="checkbox"/> M		7. Home Phone Number	
8. Employer's Name		9. Employment Date	10. Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		11. Payroll No.	
12. Occupation			13. Scheduled Number of Work Hours per Week		14. Monthly Salary \$	
15. a. Primary Beneficiary _____ b. Relationship _____			16. a. Contingent Beneficiary _____ b. Relationship _____			

<b>Section B: DEPENDENT INFORMATION (Complete if applying for Spouse or Child Individual Plan or if applying for Spouse coverage under Multi-Life Plan)</b>						
17. Name (First) (Middle) (Last)						
18. (a) Birthdate	18. (b) State of Birth	19. Age	20. Sex <input type="checkbox"/> F <input type="checkbox"/> M		21. Relationship	
22. Is Spouse/Child actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No			23. Hours Worked per Week		24. Occupation	
Complete Question 25 only if answered Question 22 "no".						
25. Is Spouse/Child currently Disabled or unable to work? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No						
26 a. Primary Beneficiary _____ b. Relationship _____			27 a. Contingent Beneficiary _____ b. Relationship _____			

<b>Section C: POLICY INFORMATION (Continued on next page)</b>						
Coverage Plans (select either an Individual or Multi-Life Plan):						
28a. Individual Plan (Separate application required for each insured)			<b>or</b>	28b. Multi-Life Plan		
<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child		<input type="checkbox"/> Employee / Spouse	<input type="checkbox"/> One Parent Family: Employee	<input type="checkbox"/> One Parent Family: Spouse
				<input type="checkbox"/> Two Parent Family		
29. Plan of Insurance applying for: <input type="checkbox"/> On and Off-Job Accident Coverage						
<input type="checkbox"/> Off-Job Accident Coverage						
<input type="checkbox"/> Reduced On & Off-Job Accident Coverage						
30. Base Policy Premium \$						
31. Will coverage applied for replace or modify any Accident or Disability insurance coverage? If "yes", provide details below and complete and submit required replacement forms if needed. .... <input type="checkbox"/> Yes <input type="checkbox"/> No						
Insured's Name			Company Name		Policy Number	

Employee Name: \_\_\_\_\_  
 (Applicant)

Employee SSN: \_\_\_\_\_  
 (Applicant)

<b>Section C: POLICY INFORMATION</b>			
32. Rider Coverage and Premiums	Employee Premium	Spouse Premium	Total Premium
Disability Income Rider or <input type="checkbox"/> Accident (Off-Job) (Section D not required) <input type="checkbox"/> Accident (Off-Job) / Sickness (Complete Section D) Employee Monthly Benefit \$ _____ Spouse Monthly Benefit \$ _____ Benefit Period _____ months Elimination Period for Accident _____ days Elimination Period for Sickness _____ days	\$	\$	\$
<input type="checkbox"/> Sickness Hospital Confinement Rider (Complete Section D)			\$
<input type="checkbox"/> Other			\$
<input type="checkbox"/> Other			\$
<b>33. Total Premium for Riders</b>			\$
<b>34. Total Premium for Base Policy and Riders (Provide sum for # 30 and # 33)</b>			
	Base Policy Premium	\$ _____	
	Total Premium for Riders	\$ _____	
		Total	\$ _____
<b>35. Payroll Premium Deducted:</b>			
<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____			
<b>POLICY EFFECTIVE DATE</b> _____		<b>TOTAL PAYROLL PREMIUM</b> \$ _____	

<b>Section D: UNDERWRITING (Complete as required for all underwritten coverage) (Continued on next page)</b>			
		Employee (Applicant)	Spouse
Accident / Sickness Disability and Sickness Hospital Confinement Rider	36. Have you or any person applying for coverage ever been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	37. Within the past 12 months, have you or any person applying for coverage received medical advice or sought treatment for insulin-dependent diabetes, any disease or abnormality of the heart, heart attack, stroke or liver disease including chronic hepatitis or been treated with 3 or more medications for high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	38. List current Height and Weight	Height _____ Weight _____	Height _____ Weight _____
Sickness Hospital Confinement Rider (Complete Questions 36-39)	39. Within the past 12 months, have you or any person applying for coverage received medical advice or sought treatment for cancer of any type including leukemia, Hodgkin's disease, melanoma (other than basal cell or squamous cell carcinoma), malignant tumors of any kind or kidney disease (other than kidney stones)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Name: \_\_\_\_\_  
 (Applicant)

Employee SSN: \_\_\_\_\_  
 (Applicant)

**Section D: UNDERWRITING (Complete as required for all underwritten coverage)**

		Employee (Applicant)	Spouse
Accident / Sickness Disability Rider  (Complete Questions 36-38, 40-42)	40. Within the past 12 months, have you or any person applying for coverage received medical advice or sought treatment for any back, knee, neck, shoulder or joint disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	41. Within the past 12 months, have you or any person applying for coverage been unable to perform normal duties of your occupation due to an injury or illness, other than normal pregnancy, for more than 10 consecutive days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	42. Do you have any group or individual disability insurance pending or in force that will not be replaced or modified? If "yes", give details.	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
Name of Company _____		Monthly Benefit _____	Elimination/Benefit Period _____

43. Have you received an Outline of Coverage form? .....  Yes  No

**Employee (Applicant) Statement**

I understand that coverage issued is based on all statements and answers recorded above. I agree that any child proposed for dependent coverage must be dependent on me for at least 50% of his / her support to be covered for benefits. These statements and answers are complete and true to the best of my knowledge and belief. I understand that as the undersigned, I am the owner of any coverage issued under this application.

I understand that the Policy Effective Date of any insurance policy issued under Provident's rules, limits or standards is shown above on the application. The Policy Effective Date will be no earlier than the application signed date and no later than the date payroll deductions begin or premium is collected for non-payroll deducted policies.

I authorize my employer to deduct the premiums for this insurance from my earnings (unless I have completed additional forms for a non-payroll method).

Dated \_\_\_\_\_ at \_\_\_\_\_  
 (Month/Day/Year) (City, State)

If this box is checked, a PIN# secured enrollment has authorized the application and a signature is not required.

Employee (Applicant) Signature

**For your protection California law requires the following to appear on this form. 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 false or deceptive statements is guilty of insurance fraud.**

**Agent Statements:** (1) Do you have knowledge or reason to believe that the proposed insurance is intended to replace any existing insurance?  Yes  No (2) To the best of your knowledge and belief, the above statements and answers are complete and true.

Dated \_\_\_\_\_  
 (Month/Day/Year)

Licensed Agent's Signature

Agent's License No. \_\_\_\_\_ Print Name of Agent \_\_\_\_\_

**Policy Number** \_\_\_\_\_

Employee Name: \_\_\_\_\_  
(Applicant)

Employee SSN: \_\_\_\_\_  
(Applicant)

### INSTRUCTIONS

**Complete the information below only if you or any person proposed for coverage on the preceding application is currently eligible for Medicare. To be eligible for Medicare, you must be either: (1) age 65 or older; or (2) disabled.**

### Medicare Certification Form

This is to certify that I have received the "Guide to Health Insurance for People with Medicare" and the "Important Notice to Persons on Medicare".

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant