

SERFF Tracking Number: CMPL-126055793 State: Arkansas
 Filing Company: Provident Life and Accident Insurance Company State Tracking Number: 41819
 Company Tracking Number: PLAIC ITL 2-2009
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
 Product Name: PLAIC ITL 2-2009
 Project Name/Number: PLAIC ITL 2-2009/PLAIC ITL 2-2009

Filing at a Glance

Company: Provident Life and Accident Insurance Company
 Product Name: PLAIC ITL 2-2009 SERFF Tr Num: CMPL-126055793 State: Arkansas
 TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- State Tr Num: 41819
 Closed
 Sub-TOI: L04I.103 Renewable - Single Life - Co Tr Num: PLAIC ITL 2-2009 State Status: Approved-Closed
 Fixed/Indeterminate Premium
 Filing Type: Form Reviewer(s): Linda Bird
 Author: Nancy French Disposition Date: 03/20/2009
 Date Submitted: 03/12/2009 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: PLAIC ITL 2-2009 Status of Filing in Domicile:
 Project Number: PLAIC ITL 2-2009 Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Group Market Size:
 Overall Rate Impact: Group Market Type:
 Filing Status Changed: 03/20/2009 Explanation for Other Group Market Type:
 State Status Changed: 03/18/2009
 Deemer Date: Created By: Nancy French
 Submitted By: Nancy French Corresponding Filing Tracking Number:
 Filing Description:
 Dear Sir/Madam:

This filing is being submitted by Compliance Research Services, LLC on behalf of Provident Life and Accident Insurance Company (Provident). A letter of filing authorization is enclosed.

Please find enclosed the above-referenced forms for your review and approval. The forms include an individual level premium term life insurance policy along with riders, endorsements and application forms associated with the policy.

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All forms are new. They do not include any provisions that are unusual. They have not been previously submitted to your state or to any other states and they will not be used in connection with any previously approved forms.

PLEASE NOTE: These forms are identical to forms approved by your Department for Reassure America Life Insurance Company on December 1, 2008 and January 15, 2009 under SERFF Tracking Numbers CMPL-125914371 and CMPL-125986342. The only differences between the approved Reassure forms and the Provident forms are:

- The form numbers, insurer name and address and the officer signatures.
- There is one less Amendatory Endorsement included in this submission than in the Reassure submission. In Amendatory Endorsement, form PAE2.0, one additional sentence has been added to the endorsement to address reinstatements that occur after the effective date of the Policy.
- The enclosed forms PAPPAMD2.0 (Amendment of Application), PUND QST2.0 (Supplemental Underwriting Questionnaire) and PSOI2.0 (Statement of Insurability) were previously approved by your Department for Reassure and were not included with the Reassure individual term life submission.

Reassure and Provident are not affiliated in any way, other than Reassure serves as reinsurer and administrator for the closed block of Provident life insurance business referenced in this submission.

The forms are submitted in final printed format except for slight font and formatting variations that may occur due to administrative production printers. Care is taken to assure that printer-based variations are minimized; however, should changes occur, such changes will not alter the content or meaning of any approved forms.

Please note that portions of the forms are bracketed to indicate variability. These areas may change as described in the attached actuarial memorandum and Statement of Variability.

Provident maintains a closed block of term life business. This product will be issued to policyholders who elect the re-entry or exchange provisions of their existing term life insurance policies. Provident also desires the ability to issue the enclosed policy as needed in the administration of its closed block of business.

Provident has designed Form PPCE2.0 to administer changes in Policy Form PTL-AR2.0 that become necessary after the policy is issued. (i.e., name changes, ownership changes, face amount increases or decreases) The form will be used to make any of the changes shown on the document titled VARIABLE LANGUAGE FOR USE WITH ENDORSEMENT FORM PPCE2.0. Should Provident wish to add new variables in the future, this form will be resubmitted to your Department for review and approval.

The Amendatory Endorsement, Form PAE2.0 is used in a policy exchange that occurs without underwriting. The rider bridges the time period for the Incontestability and Suicide provisions to the original effective date of the underlying policy.

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This submission includes actuarial memoranda for the policy and riders and demonstration of cash value requirements. Premium rates are based on the 2001 CSO table. The rates are sex distinct.

We have enclosed any certifications and transmittals required by your Department.

We appreciate your review of these forms. If you have questions or find that you need any additional information, you may reach me at 513-984-6050 or at dsimon@crssolutionsgroup.com.

Thank you for your time and attention to this filing.

Sincerely,

J. David Simon, CLU
President

Company and Contact

Filing Contact Information

Nancy French, Product Manager nrfrench@crssolutionsgroup.com
10921 Reed Hartman Highway 513-984-6050 [Phone]
Suite 334 513-984-7212 [FAX]
Cincinnati, OH 45242

Filing Company Information

(This filing was made by a third party - complianceresearchservicesllc)

Provident Life and Accident Insurance CoCode: 68195 State of Domicile: Tennessee
Company
c/o 10921 Reed Hartman Highway Group Code: 565 Company Type:
Suite 334 Group Name: State ID Number:
Cincinnati, OH 45242 FEIN Number: 62-0331200
(513) 984-6050 ext. [Phone]

SERFF Tracking Number: CMPL-126055793 State: Arkansas
Filing Company: Provident Life and Accident Insurance Company State Tracking Number: 41819
Company Tracking Number: PLAIC ITL 2-2009
TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: PLAIC ITL 2-2009
Project Name/Number: PLAIC ITL 2-2009/PLAIC ITL 2-2009

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: Policy filing includes riders and applications
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Provident Life and Accident Insurance Company	\$50.00	03/12/2009	26386809

SERFF Tracking Number: CMPL-126055793 State: Arkansas
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 Product Name: PLAIC ITL 2-2009
 Project Name/Number: PLAIC ITL 2-2009/PLAIC ITL 2-2009

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/20/2009	03/20/2009
Approved-Closed	Linda Bird	03/18/2009	03/18/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Flesch Certification	Nancy French	03/20/2009	03/20/2009
Supporting Document	Certification	Nancy French	03/20/2009	03/20/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Please re-open filing	Note To Filer	Linda Bird	03/20/2009	03/20/2009
Please re-open filing	Note To Reviewer	Nancy French	03/19/2009	03/19/2009

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Disposition

Disposition Date: 03/20/2009

Implementation Date:

Status: Approved-Closed

Comment: Company has made correction to supporting certification form.

Rate data does NOT apply to filing.

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Product Name: PLAIC ITL 2-2009
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Flesch Certification		Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Authorization		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document (revised)	Certification		Yes
Supporting Document	Certification	Replaced	Yes
Form	Level Premium Term Life Insurance Policy		Yes
Form	Accidental Death and Dismemberment Benefit Rider		Yes
Form	Waiver of Premium for Total Disability Benefit Rider		Yes
Form	Children's Term Rider		Yes
Form	Other Insured Term Rider		Yes
Form	Amendatory Endorsement		Yes
Form	Policy Change Endorsement		Yes
Form	Individual Term Life Insurance Application		Yes
Form	Re-Entry/Exchange Application		Yes
Form	Amendment of Application		Yes
Form	Supplemental Underwriting Questionnaire		Yes
Form	Statement of Insurability		Yes
Rate	RATES		Yes

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Amendment Letter

Submitted Date: 03/20/2009

Comments:

Thank you for allowing us to insert the correctly signed certifications.

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Flesch Certification

Comment:

Provident - Flesch Scores.pdf

User Added -Name: Certification

Comment:

Certificate of Compliance with Arkansas Rule and Regulation 19.pdf

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Note To Filer

Created By:

Linda Bird on 03/20/2009 07:56 AM

Last Edited By:

Linda Bird

Submitted On:

03/20/2009 07:56 AM

Subject:

Please re-open filing

Comments:

Filing has been re-opened in order for correction to be made.

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Project Name/Number: PLAIC ITL 2-2009/PLAIC ITL 2-2009

Note To Reviewer

Created By:

Nancy French on 03/19/2009 02:29 PM

Last Edited By:

Nancy French

Submitted On:

03/19/2009 02:29 PM

Subject:

Please re-open filing

Comments:

Thank you for your approval of this filing. After reviewing the documents submitted, we realized we inserted an incorrect form. Would you kindly re-open the filing to allow us the opportunity to provide the correct supporting certification form? thank you in advance for your help.

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Form Schedule

Lead Form Number: PTL-AR2.0

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	PTL-AR2.0	Policy/Cont Level Premium Term Initial ract/Fratern Life Insurance Policy al Certificate	Initial		60.000	PTL-AR2_0 AR Term Life Policy.pdf
	PADD2.0	Policy/Cont Accidental Death and Initial ract/Fratern Dismemberment al Benefit Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.000	PADD2_0 Accidental Death Rider.pdf
	PWP2.0	Policy/Cont Waiver of Premium Initial ract/Fratern for Total Disability al Benefit Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.000	PWP2_0 Waiver of Premium Rider.pdf
	PCTR2.0	Policy/Cont Children's Term Initial ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme	Initial		57.000	PCTR2_0 Children's Term Rider.pdf

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POIR2.0	Policy/Cont Other Insured Term Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	54.000	POIR2_0 Other Insured Term Rider.pdf
PAE2.0	Policy/Cont Amendatory Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	51.000	PAE2_0 Amendatory Endorsement. pdf
PPCE2.0	Policy/Cont Policy Change Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	55.000	PPCE2_0 Policy Change Endorsement with Explanation of Variables.pdf
PTL App2.0	Application/Individual Term Life Enrollment Insurance Application Form	Initial	50.000	PTLApp2_0 Application.pdf
PRE App2.0	Application/Re-Entry/Exchange Enrollment Application Form	Initial	51.000	PREApp2_0 ReEntry- Exchange Application.pdf
PAPPAMD	Application/Amendment of	Initial	54.000	PAPPAMD2_

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2.0	Enrollment Application Form				0 Application Amendment.pdf
PUND QST2.0	Application/ Supplemental Enrollment Underwriting Form Questionnaire	Initial		70.000	PUND QST2_0 Supplemental Underwriting Questionnaire .pdf
PSOI2.0	Application/ Statement of Enrollment Insurability Form	Initial		56.000	PSOI2_0 Statement of Insurability.pdf

Provident Life and Accident Insurance Company

A Stock Company

Home Office:

1 Fountain Square, Chattanooga, Tennessee 37402

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Phone: [1-800-678-6227]

'We', 'us' or 'our' means Provident Life and Accident Insurance Company. We will pay the benefits of this Policy, subject to its terms and conditions.

We will pay the Death Benefit to the Beneficiary when we receive due proof of the Insured's death before the Expiry Date and while the Policy is in force. Unless changed, the Beneficiary is as named in the application.

Right to Cancel Policy – If you are not satisfied with this Policy, you may void it by returning it to us or to our agent within 30 days after you receive it. Returning the Policy will void it from the Issue Date and we will refund all of your Premium.

READ YOUR POLICY CAREFULLY. This Policy is a legal contract between the Owner and us. This Policy is issued in consideration of the application and payment of the initial Premium.

Signed for Provident Life and Accident Insurance Company at its Home Office.



President



Corporate Secretary

**Level Premium Term Life Insurance Policy for a Specified Duration;
Thereafter Annually Renewable
Term Life Insurance to Policy Age 100 with Increasing Premium
Convertible During Conversion Period**

**Death Benefit Payable Upon Death, Before Expiry Date
Premium Payable to Expiry Date
Nonparticipating**

[A War Risk Exclusion is Contained in the [Waiver of Premium Rider] [and] [Accidental Death and Dismemberment Rider] attached to This Policy]

This Policy is issued for delivery in [insert issue state]. The telephone number for the [insert issue state] Department of Insurance is [insert Insurance Department telephone number] .

Guide to Policy Provisions

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Policy Data (Cont'd)

Table of Annual Policy Premiums⁵ – The {\$XX} annual Policy fee is included in the Premiums shown below.

Policy Year	Term Life Premium	Total Premium	Policy Year	Term Life Premium	Total Premium
1	85.90	139.90	46	1868.00	1868.00
2	85.90	140.60	47	2070.80	2070.80
3	85.90	141.20	48	2285.50	2285.50
4	85.90	141.70	49	2520.00	2520.00
5	85.90	142.30	50	2780.80	2780.80
6	85.90	143.00	51	3070.80	3070.80
7	85.90	143.80	52	3389.80	3389.80
8	85.90	144.70	53	3734.50	3734.50
9	85.90	145.80	54	4101.00	4101.00
10	85.90	147.10	55	4485.50	4485.50
11	136.00	198.70	56	4868.50	4868.50
12	141.80	206.30	57	5245.50	5245.50
13	146.50	213.10	58	5640.50	5640.50
14	150.30	219.20	59	6057.00	6057.00
15	155.00	226.50	60	6495.80	6495.80
16	161.30	235.70	61	6930.30	6930.30
17	169.30	247.00	62	7354.50	7354.50
18	179.00	260.40	63	7806.50	7806.50
19	190.30	275.60	64	8288.50	8288.50
20	204.50	293.90	65	8802.80	8802.80
21	220.50	314.60			
22	237.00	336.20			
23	253.00	357.60			
24	269.00	379.20			
25	287.80	403.70			
26	310.50	432.40			
27	338.30	466.80			
28	370.50	506.00			
29	405.80	548.70			
30	442.50	593.50			
31	480.80	480.80			
32	519.50	519.50			
33	560.00	560.00			
34	602.80	602.80			
35	650.80	650.80			
36	706.80	706.80			
37	774.80	774.80			
38	854.30	854.30			
39	938.00	938.00			
40	1028.00	1028.00			
41	1126.00	1126.00			
42	1236.50	1236.50			
43	1365.00	1365.00			
44	1514.30	1514.30			
45	1681.50	1681.50			

⁵ The Total Premium amounts in the Table of Annual Policy Premiums include the premiums for any Riders attached to the Policy.

Policy Data (Cont'd)

For Other Frequency of Premium Multiply the Total Premium by:

.52 for Semi-Annual;

.275 for Quarterly;

.09 for Monthly.

Contact our Administrative Office for more information about the coverage provided under your Policy:

Provident Life and Accident Insurance Company

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Phone: [1-800-678-6227]

General Provisions

The Policy - This Policy, the application and any riders or endorsements attached hereto are the entire Policy. A copy of the application is attached.

Only our officers may change this Policy or waive a right or requirement stated herein. No agent may do this.

Owner - 'You' or 'your' means the Owner. Unless changed, the Owner is as named in the application. If all named Owners and contingent Owners have died, the Owner of this Policy is the last surviving Owner's estate.

You may exercise all Policy rights while this Policy is in force. These include the right to:

1. Change the Beneficiary;
2. Change the Owner;
3. Assign this Policy, subject to the rights of an irrevocable Beneficiary, if any; and
4. Receive benefits.

If there is more than one Owner, we must receive written consent of all Owners for the exercise of any ownership right.

Age – Age means the Insured's age on his or her last birthday.

Beneficiary - Beneficiary means the person(s) or other designated entity(ies) you name on the application or on a form satisfactory to us who will receive the Death Benefit upon the death of the Insured. The Beneficiary cannot be the Insured. A Beneficiary that is irrevocable may not be changed without the written consent of that Beneficiary. You may designate different classes of Beneficiaries such as primary (first) and contingent (second). These classes set the order of payment. A class may contain more than one Beneficiary. The Death Benefit will be paid in equal shares to the then living person(s) in the class with the highest priority unless you have designated otherwise. If you have (1) designated multiple Beneficiaries in a class, (2) designated a percentage payable to each such Beneficiary, and (3) one or more of the designated Beneficiaries are not alive at the death of the Insured, the interest of the deceased Beneficiary(ies) in the Death Benefit will be equally distributed to the surviving Beneficiary(ies) of the class.

If no Beneficiaries are alive at the death of the Insured, the Death Benefit will be paid to the Owner or, if no owner survives the Insured, to the Owner's estate.

Change of Owner or Beneficiary - Unless you state otherwise, you may change the Owner or Beneficiary while the Insured is alive. The request must be made in writing in a form acceptable to us. The request will take effect on the date you sign the request to change the Owner or Beneficiary unless you request a different date. However, we are not liable for any payments made or actions taken prior to our receipt of your written and signed request in our Administrative Office.

Premiums - Premiums are shown on the Policy Data page. Policy months and years are measured from the Issue Date. Premiums are to be paid on or before the Premium due date, with the first premium due, as shown on the Policy Data page, on the Issue Date. The Policy Data page also shows the frequency of Premiums that are due in the future. All Premiums must be received by us at our Administrative Office on or before the Premium due date.

You may change the frequency with which you pay Premium upon written request to us. If you do, the amount of the Premium will change. The change will take effect as of the start of the next Policy year. The Death Benefits to be paid at the Insured's death will include a refund of Premium paid for any coverage beyond the Policy month of the Insured's death.

Grace Period - If we do not receive your Premium by its due date, we will allow a Grace Period of 31 days. This Policy will be in force during the Grace Period. If we do not receive the Premium by the end of the Grace Period, this Policy will terminate. If the Insured dies during the Grace Period, we will deduct any Premium due us from the Death Benefits we pay. Any Premium received by us after the Policy terminates will be refunded to the Owner.

Expiry Date - is the date that insurance coverage under this Policy ends. **The date is shown on the Policy Data page.**

Reinstatement - You may reinstate this Policy - that is, put it back in full force, up to 5 years past the due date of the first Premium not received by us by the end of the Grace Period. You may only reinstate the policy if it terminated due to non-payment of sufficient Premium.

We will reinstate the Policy if you:

1. Give us due proof satisfactory to us that the Insured is still insurable based on our current underwriting guidelines;
2. Pay all due Premiums not yet paid with interest at the Reinstatement interest rate of 6% annually from the due date of each Premium.

Assignment - You may assign this Policy. Any Assignment must include written consent by the irrevocable Beneficiary, if any. We are not responsible for the validity of an Assignment. The Assignment will take effect on the date you sign such Assignment unless you request a different date. However, we are not liable for any payments made or actions taken prior to our receipt of a written and signed Assignment in our Administrative Office. The rights of the Owner and the Beneficiary are subject to the rights of the person or entity to whom this Policy is assigned.

Misstatement of Age and/or Gender - If the Insured's age and/or gender shown on the application is misstated, the death benefit payable shall be the amount which the Premium paid would have purchased at the correct age and/or gender, according to our rates in effect on the Issue Date.

Incontestability – After this Policy has been in force while the Insured is alive for 2 years from its Issue Date, it will be incontestable as to the statements made in the application. In the absence of fraud, all statements made in the application are deemed to be representations and not warranties. No statement will be used by us in defense of a claim or to void this Policy unless it is in the signed application. This does not prevent us from terminating this Policy if Premiums are due but not paid. A new period of incontestability will apply if reinstatement occurs.

Suicide - If the Insured dies by Suicide while sane or insane within 2 years from the Issue Date of this Policy, payment will be limited to a refund of all the Premiums paid, and the policy shall terminate. Any such Premium refund will be paid to the Owner or, if no owner survives the Insured, to the Owner's estate.

Nonparticipating – This Policy is Nonparticipating. It does not share in our profits or surplus earnings. We will pay no dividends on this Policy.

Death Benefit

If the Insured dies while this Policy is in force prior to the Expiry Date, we will pay a Death Benefit in one sum to the Beneficiary, to the extent possible, within 31 days upon our receipt of:

1. Due proof of the Insured's death in a form acceptable to us, such as a certified copy of the death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the Death Benefit; and
2. A fully completed claim form, including all required documentation.

The Death Benefit will be (a) the Face Amount on the date of death as shown on the Policy Data page, plus (b) any additional benefits provided by Riders, plus (c) the portion of any unearned Premiums, and (d) less any premiums due. The Death Benefit is equal to or greater than the guaranteed minimum benefits required by the state in which this Policy is delivered.

If we defer the Death Benefit payment 31 days or more after our receipt of due proof of the Insured's death, the Death Benefit will include interest at the rate of eight percent (8%) per year beginning with the date of death until the date the claim is paid.

Payment of the Death Benefit is subject to the interest of any assignee of record. Death Benefits paid to satisfy any assignee shall be paid in one sum. If no Beneficiary survives the Insured, we will pay the Death Benefit to you, if you are living; otherwise to your estate. Payment of the Death Benefit discharges us from all claims associated with this Policy.

Renewal Provision

After the end of the level term period, you may renew this Policy on each Policy anniversary by paying the Premium shown in the Table of Annual Policy Premiums. Each renewal is for a period of one year and runs to the next Policy anniversary. This Policy may not be renewed on or after the Expiry Date.

The first premium paid for each renewal period is payable as stated in the "Premiums" provision.

If the Insured dies within 31 days after a Policy anniversary for a renewal period, but before the first premium for the renewal period has been paid, we will consider this Policy to have been renewed. The unpaid premium will be deducted from the Death Benefit. If the Insured is alive at the end of the 31 days after any Premium Due Date and if the premium due has not been paid, this Policy is beyond the Grace Period and no longer in force.

This Policy will be renewed automatically on any Policy anniversary on which premiums are being waived under any Waiver of Premium Rider attached to this Policy.

Conversion Provision

While this Policy is in force, you may convert the term insurance on the life of the Insured to any permanent life insurance plan we then issue, subject to the issue age and minimum death benefit limits. Evidence of insurability is not required.

Application – We must receive an application for conversion and the first premium for the new policy at our Administrative Office during the Conversion Period shown on the Policy Data page.

Amount - The Face Amount of the new policy may not exceed the Face Amount under this Policy. However, we will consider an increase in your Face Amount, subject to the following conditions:

1. you must submit satisfactory evidence of insurability; and
2. the increase in coverage must be underwritten in accordance with our current underwriting rules and practices.

The minimum Face Amount of the new policy is the lesser of: a) the Face Amount of this Policy; or b) \$10,000. The maximum Face Amount of the new policy is \$1,000,000.

New Policy Issue Date - The new policy issue date will be the date of the application, but only if the Insured is then alive. We will refund any portion of premium paid for coverage under this Policy which extends past the issue date for the new policy. The new policy will be subject to any Assignment of this Policy recorded at our Administrative Office.

Premiums – Premiums for the new policy will be based on:

1. The Premium class, Age and Gender for the Insured shown on the Policy Data page of this Policy;
2. Our rates then in effect; and
3. The Other Insured Person's age on the issue date of the new policy.

Supplemental Benefits – Supplemental benefits included in this Policy by Rider may be included in the new policy, subject to our issue rules and the premium rates in effect on the Conversion Date.

Incontestability and Suicide Provisions – The Incontestability and Suicide provisions of the new policy are effective from the issue date of coverage under this Policy.

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Provident Life and Accident Insurance Company

A Stock Company

Home Office:

1 Fountain Square, Chattanooga, Tennessee 37402

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Phone: [1-800-678-6227]

**Level Premium Term Life Insurance Policy for a Specified Duration;
Thereafter Annually Renewable
Term Life Insurance to Policy Age 100 with Increasing Premium
Convertible During Conversion Period**

**Death Benefit Payable Upon Death, Before Expiry Date
Premium Payable to Expiry Date
Nonparticipating**

**[A War Risk Exclusion is Contained in the [Waiver of Premium Rider] [and]
[Accidental Death and Dismemberment Rider] attached to This Policy]**

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT RIDER

Provident Life and Accident Insurance Company
Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402
Administrative Office:
[Post Office Box 9000]
[Coppell, Texas 75019-9000]
Phone: [1-800-678-6227]

This Rider is a part of the Policy to which it is attached. It is subject to all provisions, terms, conditions and definitions of the Policy unless stated otherwise in this Rider. This Rider has no cash value or loan values.

Premium – The Premium for this Rider is shown on the Policy Data page.

Effective Date - This Rider is issued with the Policy and its Effective Date is the Issue Date shown on the Policy Data page. This Rider will not become effective unless the Policy is in force.

Definitions – The following terms are used in this Rider in addition to the terms in the Policy.

Accidental Death means death which results directly from accidental bodily Injury and independently from all other causes.

Covered Accident means an accident:

- a. that occurs on or after the Effective Date of this Rider;
- b. that is not caused by or results from an exclusion listed in the Exclusions provision in this Rider;
and
- c. that occurs while the Policy and this Rider are in force.

Covered Loss means: (1) the accidental death of the Insured caused by Injury sustained in a Covered Accident as provided under the "Accidental Death Benefit" provision; and (2) a physical dismemberment listed as a Covered Loss under the "Dismemberment Benefit" provision.

Injury means an accidental bodily Injury sustained by the Insured that is the direct result of a Covered Accident. Injuries must be independent of disease or bodily or mental illness or infirmity or any other cause.

Insured means the person named as the Insured on the Policy Data page.

Accidental Death Benefit

If the Insured dies of Injuries sustained in a Covered Accident, independent of all other causes, such death will be a Covered Loss under this Rider, and we will pay the Principal Sum to the Insured's Beneficiary. The Principal Sum is shown on the Policy Data page. The Insured's death must occur:

- a. within one hundred eighty (180) days after a Covered Accident;
- b. while the Policy and this Rider are in force; and
- c. prior to the end of the Policy year nearest the Insured's 65th birthday.

The accidental bodily Injury resulting in loss of life of the Insured must be:

- a. shown by a visible contusion or wound on the exterior of the body;
- b. an internal Injury revealed by autopsy; or
- c. an accidental drowning.

Dismemberment Benefit

If the Insured, as a result of bodily Injury caused by accident occurring while this Rider is in force and resulting directly and independently of all other causes, suffers any of the following Covered Losses within 90 days after the date of the Covered Accident, we will pay the percentage of the Principal Sum shown below for the Covered Losses. The Principal Sum is shown on the Policy Data page.

<u>Covered Loss</u>	<u>Amount of Principal Sum Payable</u>
Loss of Both Hands or Both Feet	100%
Loss of Sight in Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Sight of One Eye	100%
Loss of One Foot and Sight of One Eye	100%
Loss of One Hand or One Foot or Sight of One Eye	50%

“Loss of hand or foot” means the complete physical severance through or above the wrist or ankle joint so that no part of the hand or foot remains. “Loss of sight” of the eye means the total and permanent loss of sight of the eye.

Multiple Losses Incurred in an Accident - If the Insured incurs more than one Covered Loss resulting from one accident, the provisions of this Rider will be applicable to only one of such Covered Losses. This Rider will pay for the Covered Loss that provides the greatest benefit amount payable under this Rider. No benefits will be paid under any circumstances for any loss that is not a Covered Loss under this Rider.

Exclusions - We will not pay any benefits under this Rider if the Insured’s death or dismemberment:

1. is caused or contributed to by an intentionally self-inflicted Injury, or suicide or attempted suicide, while sane or insane;
2. is caused or contributed to by a disease or infirmity of the mind or body, or medical or surgical treatment for such disease or infirmity;
3. is caused or contributed to by an infection not occurring as a direct result or consequence of the accidental bodily injury;
4. is caused or materially contributed to by a voluntary intake or use by any means of:
 - a. any drug, unless prescribed or administered by a physician and taken in accordance with the physician’s instructions; or
 - b. poison, gas or fumes, unless a direct result of an occupational accident;
5. is caused or contributed to by an injury resulting from an accident that occurred prior to the Effective Date of this Rider;
6. is caused or contributed to by committing or attempting to commit a felony;
7. is caused or contributed to by active participation in a riot, insurrection or terrorist activity;
8. is caused or contributed to by intoxication as defined by the jurisdiction where the accident occurred;
9. is caused or materially contributed to by participation in an illegal occupation or activity;
10. occurs while the Insured is incarcerated;
11. is caused or contributed by riding or driving an air, land, or water vehicle in a race, speed or endurance contest;

12. is caused or contributed by rock climbing or mountain climbing;
 13. is caused or contributed by bungee jumping;
 14. is caused or contributed by aeronautics (hang-gliding, skydiving, parachuting, ultralight, soaring, ballooning and parasailing);
 15. is caused or contributed to by War or an Act of War, if the cause of death occurs:
 - a. while the Insured is serving in the military, naval or air forces of any country, combination of countries or international organization, or is serving in any civilian non-combatant unit serving with such forces, provided such death occurs while serving in such forces or unit or within six (6) months after termination of service in such forces or unit; or
 - b. as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, or to service in any civilian non-combatant unit serving with such forces, if the cause of death occurs while the insured is serving in such forces or units and is outside the Home Area, provided such death occurs outside the Home Area or within six (6) months after the insured's return to the Home Area or area in such forces or within six (6) months after the termination of service in such forces or units, whichever is earlier; or
 - c. within two (2) years from the date of issue of the policy, while the Insured is not serving in such forces or units, if the cause of death occurs while the insured is outside the home area, provided such death occurs outside the Home Area or within six (6) months after the insured's return to the Home Area.
- "Home Area" means the fifty (50) states of the United States and its territories, the District of Columbia and Canada.
- "War" includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.
- "Act of War" means any act peculiar to military, naval or air operations in time of war.
16. is caused or contributed to by operating, descending from or riding in any type of aircraft or space craft. This exception does not apply to a passenger with no duties on board an aircraft operated:
 - a. commercially to transport passengers for hire; or
 - b. by a private business to transport its personnel or guests.

Payment of Claims – Benefits payable under this Rider for Accidental Death will be paid upon receipt of due written proof and notice of claim in a form acceptable to us. We will pay this benefit in addition to the death benefit described in the Policy to which this Rider is attached. Accidental Death Benefits will be paid to the Beneficiary, if living; otherwise, benefits will be paid to the Owner's estate. Benefits payable for a Covered Loss under the Dismemberment Benefit will be paid to the Insured.

Physical Examination and Autopsy - We have the right, at our own expense, to examine the body of the Insured and have an autopsy performed unless prohibited by law.

Incontestability – The Incontestability provision of the Policy applies to this Rider.

Termination - This Rider will automatically terminate on the earliest of:

1. The Policy Anniversary on which the Insured attains age 65;
2. The date of the death of the Insured;

3. The date the Policy terminates for any reason, including the Expiry Date or nonpayment of Premium when due;
4. At the end of the Policy Grace Period if the Premium for this Rider is not received by the end of the Grace Period.

The Owner may terminate this Rider on any Premium due date by sending us a written request before that date and returning the Rider to us.

Termination of this Rider shall not prejudice the payment of benefits for any accident that occurred while this Rider was in force.

Signed for the Provident Life and Accident Insurance Company at its Home Office.


President


Corporate Secretary

WAIVER OF PREMIUM FOR TOTAL DISABILITY BENEFIT RIDER

Provident Life and Accident Insurance Company
Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402
Administrative Office:
[Post Office Box 9000]
[Coppell, Texas 75019-9000]
Phone: [1-800-678-6227]

This Rider is a part of the Policy to which it is attached. It is subject to all provisions, terms, conditions and definitions of the Policy unless stated otherwise in this Rider. This Rider has no cash value or loan values.

Effective Date - This Rider is issued with the Policy and its Effective Date is the Issue Date shown on the Policy Data page. This Rider will not become effective unless the Policy is in force.

Definitions – The following terms are used in this Rider in addition to the terms in the Policy.

Injury means accidental bodily injury that occurs while this Rider is in force and results directly and independently of all other causes of loss covered under this Rider.

Insured means the person named as the Insured on the Policy Data page.

Policy Month means a period of one month starting on the Issue Date. Later Policy Months start on the monthly anniversary of the Issue Date. All Policy Months end on the day before the next monthly anniversary.

Sickness means sickness or disease, which is diagnosed and treated while this Rider is in force. Sickness also means medical conditions admitted in the application.

Total Disability and **Totally Disabled** means:

1. **During the first 24 months of total disability**, the insured is unable to perform the substantial and material duties of their job due to sickness or accidental bodily injury.
2. **After the first 24 months of total disability**, the insured, due to sickness or accidental bodily injury, is unable to perform any of the substantial and material duties of their job, or any other job for which the Insured becomes reasonably suited by education, training or experience.

To be covered by this Rider, the Insured's Total Disability must begin while this Rider is in force.

Even if the Insured is able to work, the total loss of any of the following will be considered total disability as long as the loss continues:

- a. the sight of both eyes;
- b. the use of both hands;
- c. the use of both feet; or
- d. the use of one hand and one foot.

Benefit – This Rider will waive the Premium for the Policy should the Insured become Totally Disabled while the Policy and Rider are in force. The Premium will be waived if we receive proof that:

1. the Insured has been totally and continuously disabled for at least 180 days; and
2. the Total Disability began while this Rider was in force, and prior to the Insured's age 65.

If the Total Disability began on or after the Insured's age 60, the maximum Benefit period will be 60 months.

Premiums will be waived beginning with the Policy Month following the date the Insured becomes Totally Disabled. However, we will not waive Premiums for any Policy Month which began more than one year before the date we receive proof of the Insured's Total Disability at our Administrative Office. We will refund the portion of any Premium paid for a Policy Month for which we waive Premiums. While we are waiving premiums, all benefits included under the Policy shall continue in force.

If the Insured dies while Premiums are being waived under the terms of this Rider, such Premiums will not be deducted from the Death Benefits we pay.

This Waiver of Premium benefit does not apply to the Total Disability of any person other than the person named as the Insured on the Policy Data page.

Exclusions - No benefit will be provided under this Rider if the Insured's Total Disability:

1. is caused or contributed to by any attempt at suicide, or intentionally self-inflicted Injury, while sane or insane;
2. is caused or materially contributed to by voluntarily intake or use by any means of:
 - a. any drug, unless prescribed or administered by a physician and taken in accordance with the physician's instructions; or
 - b. poison, gas or fumes, unless a direct result of an occupational accident;
3. is caused or contributed to by war or an Act of War, if the cause of Total Disability occurs:
 - a. while the Insured is serving in the military, naval or air forces of any country, combination of countries or international organization, or is serving in any civilian non-combatant unit serving with such forces, provided such Total Disability occurs while serving in such forces or unit or within six (6) months after termination of service in such forces or unit; or
 - b. as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, or to service in any civilian non-combatant unit serving with such forces, if the cause of Total Disability occurs while the insured is serving in such forces or units and is outside the Home Area, provided such Total Disability occurs outside the Home Area or within six (6) months after the insured's return to the Home Area or area in such forces or within six (6) months after the termination of service in such forces or units, whichever is earlier; or
 - c. within two (2) years from the date of issue of the policy, while the Insured is not serving in such forces or units, if the cause of Total Disability occurs while the insured is outside the home area, provided such Total Disability occurs outside the Home Area or within six (6) months after the insured's return to the Home Area.

"Home Area" means the fifty (50) states of the United States and its territories, the District of Columbia and Canada.

"War" includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.

"Act of War" means any act peculiar to military, naval or air operations in time of war.

4. is caused or contributed to by intoxication as defined by the jurisdiction where the total disability occurred;
5. is caused or materially contributed to by participation in an illegal occupation or activity;
6. is caused or contributed to by any condition disclosed in the application and explicitly excluded in a form attached to the policy;
7. is caused or contributed to by committing or attempting to commit a felony;
8. caused or contributed to by active participation in a riot, insurrection or terrorist activity; and/or
9. occurs after the benefit anniversary on which the Insured attains age 65.

Incontestability – The Incontestability provision of the Policy applies to this Rider.

Notice and Proof of Total Disability – We must receive written notice of claim and proof in a form satisfactory to us of the Insured's Total Disability while the Insured is alive and remains Totally Disabled. Such notice and proof must be received at our Administrative Office.

An otherwise valid claim will not be denied if notice and proof is given to us as soon as reasonably possible but no more than one year after the Insured's age 65.

Proof of Continuance of Total Disability – During the first 2 years after we approve the claim for the Insured's Total Disability, we may at reasonable intervals require proof that the Insured is still Totally Disabled. Thereafter, we will not require proof more often than once a year.

As part of any proof, we may require that the Insured be examined by one or more physicians of our choice and at our expense.

Recurring Disability – The requirement that a Total Disability continue for at least 180 days will be waived if:

1. The Insured has had a previous period of Total Disability due to the same or related causes for which we waived payments under this Rider;
2. The Insured has returned to Full Time Employment; and
3. The new period of Total Disability began while this Rider was in force and within 30 days of the end of the previous period.

Full Time Employment means the performance of services rendered for wage or profit at a rate of no less than 30 hours per week.

Premium – Any Premium that becomes due during the Insured's Total Disability, but before we approve a claim, is payable to us. If we approve the claim, we will refund any Premium paid which is eligible for waiver. Any unpaid Premium that was due before the Insured's Total Disability began must be paid to us.

The Owner must again pay Premiums for the Policy beginning with the Policy month following the earliest of:

1. Failure to furnish any required proof of the Insured's Total Disability;
2. The last date the Insured is Totally Disabled; or

3. The end of the 60-month benefit period if the Total Disability began on or after the Insured attained age 60.

If the frequency between Premium payments is not monthly, we will charge a pro rata amount to the due date of the next Premium. The annual Premium for this Rider, if any, is shown on the Policy Data page.

If Total Disability begins during the Policy's Grace Period, payment of overdue premium is required to avoid lapse of the Policy before we waive premiums.

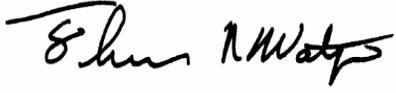
Termination – This rider will automatically terminate on the earliest of the following:

1. The Policy Anniversary on which the Insured attains age 65;
2. The date of the death of the Insured;
3. The date the Policy terminates for any reason, including nonpayment of Premium when due;
4. At the end of the Policy Grace Period, if the premium for this Rider is not received by the end of the Grace Period.
5. Upon written request from the Owner;

The Owner may terminate this Rider on any Premium due date by sending us a written request before that date and returning the Rider to us.

Termination of this Rider will not affect an otherwise valid claim for Total Disability that began before this Rider terminated.

Signed for Provident Life and Accident Insurance Company at its Home Office.


President


Corporate Secretary

CHILDREN'S TERM RIDER

Provident Life and Accident Insurance Company

Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Phone: [1-800-678-6227]

This Rider is a part of the Policy to which it is attached. It is subject to all provisions, terms, conditions and definitions of the Policy unless stated otherwise in this Rider.

Death Benefit – We will pay the Death Benefit of this Rider to the designated Beneficiary upon receiving due proof in a form acceptable to us that the death of an Insured Child occurred while coverage for this Rider was in force. The Death Benefit amount is shown on the Policy Data page. There is no cash value or loan value associated with this Rider.

Insured Child – An Insured Child is:

1. A child, stepchild or legally adopted child of the Insured named in the application for this Rider, who at the Issue Date for this Rider has reached the age of 15 days, and has not yet reached the age of 18 years;
2. A child born to the Insured after the Issue Date of this Rider once the child has reached the age of 15 days, and has not yet reached the age of 18 years; or
3. A child legally adopted by the Insured provided that the child has reached the age of 15 days, and as of the date of the adoption, has not yet reached the age of 18 years.

Insured – The person shown as the Insured on the Policy Data page.

Premium and Effective Date – The Premium for this Rider is shown on the Policy Data page. The Issue Date of this Rider is the same as the Issue Date for the Policy.

Incontestability – The Incontestability provision of the Policy applies to this Rider.

Reinstatement – The Reinstatement provision of the Policy applies to this Rider.

Beneficiary - Beneficiary means the person named on the application or on a form satisfactory to us who will receive the Death Benefit upon the death of the Insured Child. If the Beneficiary is not alive at the death of the Insured Child, the Death Benefit will be paid to the Owner or, if no owner survives the Insured, to the Owner's estate.

Change of Beneficiary - You may change the Beneficiary while the Policy and the Rider are in force and the Insured Child is alive. The request must be made in writing in a form acceptable to us. The request will take effect on the date you sign the request to change the Beneficiary. However, we are not liable for any payments made or actions taken prior to our receipt of your written and signed request in our Administrative Office.

Death of the Insured – If the Insured dies while this Rider is in force, coverage under this Rider will terminate at the end of the Policy month of the Insured's death. We will refund unearned Premium paid for coverage under this Rider beyond the Policy month of the Insured's death.

Conversion Provision

While this Rider is in force, you may convert the term insurance on the life of the Insured Child to any permanent life insurance plan we then issue subject to the issue age and minimum Death Benefit limits. We will not require evidence of insurability.

Conversion Date – An Insured Child may convert the coverage under this Rider on the Policy Anniversary following the Child's 18th birthday. Otherwise, an Insured Child's conversion date is the earliest of:

1. The Policy Anniversary nearest the Insured Child's 25th birthday;
2. The Policy Anniversary when the Insured's age is 65; or
3. The date of death of the Insured.

Application – We must receive an application for conversion and the first payment for the new policy at our Administrative Office no later than 31 days after the conversion date.

Amount - The Face Amount of the new policy may not be less than the minimum required for the plan or more than 5 times the amount of the Death Benefit of this Rider.

New Policy Issue Date – The issue date of the new policy will be the later of:

1. The day following the conversion date; or
2. The date of the application, but only if the Insured Child to be insured under the new policy is then alive. The suicide and incontestability periods for the new policy will be measured from the Issue Date of this Rider.

Premiums – Premiums for the new policy will be based on:

1. Our rates then in effect; and
2. The Insured Child's age and gender on the issue date of the new policy.

Temporary Death Benefit – If the Insured Child should die:

1. During the 31-day period after the conversion date; and
2. Before the issue date of the new policy,

We will pay a Death Benefit to the Beneficiary equal to the Death Benefit under this Rider.

Termination of Conversion Right – Unless previously converted, an Insured Child's right to convert coverage under the Children's Term Rider will automatically terminate on the Policy Anniversary following that Insured Child's 25th birthday or, if earlier, the date this Rider terminates.

Termination

Termination - This Rider will automatically terminate on the earliest of:

1. The Policy Anniversary on which the Insured attains age 65;
2. The date of the death of the Insured;
3. The date the Policy terminates for any reason, including nonpayment of Premium when due;
4. At the end of the Policy Grace Period if the Premium for this Rider is not received by the end of the Grace Period;
5. When each and every Insured Child subject to this Rider has turned age 25.

The Owner may terminate this Rider effective any Premium due date by sending us a written request before that date and returning the Rider to us.

Signed for the Provident Life and Accident Insurance Company at its Home Office.


 {
 President
 }


 {
 Corporate Secretary
 }

OTHER INSURED TERM RIDER

Provident Life and Accident Insurance Company

Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Phone: [1-800-678-6227]

This Rider is a part of the Policy to which it is attached. It is subject to all provisions, terms, conditions and definitions of the Policy unless stated otherwise in this Rider.

Death Benefit – We will pay the Death Benefit of this Rider to the designated Beneficiary upon receiving due proof in a form acceptable to us that the death of the Other Insured Person occurred while coverage under this Rider was in force. The Death Benefit amount is shown on the Policy Data page. There is no cash value or loan value associated with this Rider.

Other Insured Person – The person named on the Policy Data page as the Other Insured Person.

Insured – The person shown as the Insured on the Policy Data page.

Premium and Effective Date – The Premium for this Rider is shown on the Policy Data page. The Issue Date of this Rider is the same as the Issue Date for the Policy.

Incontestability – The Incontestability provision of the Policy applies to this Rider.

Reinstatement – The Reinstatement provision of the Policy applies to this Rider.

Suicide – If the Other Insured Person dies by Suicide while sane or insane within 2 years from the Issue Date of this Rider, payment will be limited to a refund of the Premiums paid for this Rider. Any such Premium refund will be paid to the Owner or, if no owner survives the Other Insured Person, to the Owner's estate.

Incorrect Age or Sex – If the Other Insured Person's age or sex shown on the application is misstated, we will change the Death Benefit we pay to the amount which the Premiums paid would have bought at the correct age and sex according to our rates in effect on the Issue Date.

Beneficiary - Beneficiary means the person named on the application or on a form satisfactory to us who will receive the Death Benefit upon the death of the Other Insured Person. If the Beneficiary is not alive at the death of the Other Insured Person, the Death Benefit will be paid to the Owner or, if no owner survives the Insured, to the Owner's estate.

Change of Beneficiary - You may change the Beneficiary while the Policy and the Rider are in force and the Other Insured Person is alive. The request must be made in writing in a form acceptable to us. The request will take effect on the date you sign the request to change the Beneficiary. However, we are not liable for any payments made or actions taken prior to our receipt of your written and signed request in our Administrative Office.

Death of the Insured – If the Insured dies while this Rider is in force, coverage under this Rider will terminate at the end of the Policy month of the Insured's death. We will refund unearned Premium paid for coverage under this Rider beyond the Policy month of the Insured's death.

Conversion Provision

While this Rider is in force, you may convert the term insurance on the life of the Other Insured Person to any permanent life insurance plan we then issue subject to the issue age and minimum death benefit limits. We will not require evidence of insurability.

Application – We must receive an application for conversion and the first premium for the new policy at our Administrative Office before the Other Insured Person's 65th birthday.

Amount - The Face Amount of the new policy cannot exceed the Other Insured Person's Death Benefit under this Rider.

New Policy Issue Date - The new policy issue date will be the date of the application, but only if the Other Insured Person is then alive.

Premiums – Premiums for the new policy will be based on:

1. The Premium class and gender for the Other Insured Person shown on the Policy Data page;
2. Our rates then in effect; and
3. The Other Insured Person's age on the issue date of the new policy.

Temporary Death Benefit – If the Other Insured Person should die:

1. During the 31-day period after the conversion date; and
2. Before the issue date of the new policy,

we will pay a Death Benefit to the Beneficiary equal to the Death Benefit under this Rider.

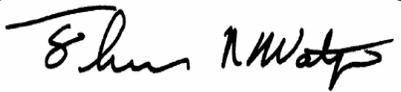
Termination

Termination - This Rider will automatically terminate the earliest of:

1. The Policy anniversary on which the Insured attains age 65;
2. The date of the death of the Insured;
3. The date the Policy terminates for any reason, including nonpayment of Premium when due;
4. At the end of the Policy Grace Period if the Premium for this Rider is not received by the end of the Grace Period.

The Owner may terminate this Rider effective any Premium due date by sending us a written request before that date and returning the Rider to us.

Signed for the Provident Life and Accident Insurance Company at its Home Office.


President


Corporate Secretary

AMENDATORY ENDORSEMENT

Provident Life and Accident Insurance Company

Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Phone: [1-800-678-6227]

THIS ENDORSEMENT CHANGES YOUR POLICY, PLEASE READ IT CAREFULLY

This Endorsement is part of the Policy to which it is attached and is effective as of the Policy Issue Date. All Policy terms will apply to this Endorsement unless they: (a) have been changed by this Endorsement; or (b) conflict with this Endorsement.

This Policy has been issued in accordance with the Guaranteed Exchange Benefit Rider of your original term life insurance policy. Therefore, the **Incontestability** and **Suicide** provisions of the Policy are revised as follows:

Incontestability – After 2 years from the Policy Date/Issue Date of the original term life insurance policy while the Insured is alive, the Policy will be incontestable as to the statements made in the application for the original term insurance policy. In the absence of fraud, all statements made in the application are deemed to be representations and not warranties. No statement will be used by us in defense of a claim or to void this Policy unless it is in the signed application. This does not prevent us from terminating this Policy if Premiums are due but not paid. If the original term life insurance policy was reinstated, a new two year contestable period applies from the date of reinstatement with respect to statements made in the application for reinstatement. A new period of incontestability will apply if reinstatement occurs after the Policy Date/Issue Date of this Policy.

Suicide - If the Insured dies by Suicide while sane or insane within 2 years from the Policy Date/Issue Date of the original term life insurance policy, the Death Benefit payable under the Policy will be limited to a refund of all Premiums paid and the Policy will terminate.

Signed for Provident Life and Accident Insurance Company at its Home Office.


Corporate Secretary

POLICY CHANGE ENDORSEMENT

Provident Life and Accident Insurance Company

Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402

Administrative Office:

[Post Office Box 9000]

[Coppel, Texas 75019-9000]

Phone: [1-800-678-6227]

This Endorsement is part of the Policy to which it is attached. All Policy terms will apply to this Endorsement unless they: (a) have been changed by this Endorsement; or (b) conflict with this Endorsement.

Policy Number: 12345678

Endorsement Effective Date: April 1, 2008

Owner Name: John Doe

Owner Address: 123 Main Street, Anytown, USA 99999

Insured Name: Jane Doe

It is hereby agreed and understood that the Policy to which this endorsement is attached is hereby amended as follows:

Signed for Provident Life and Accident Insurance Company at its Home Office.


Corporate Secretary

VARIABLE LANGUAGE FOR USE WITH ENDORSEMENT FORM PPCE2.0

Provident Life and Accident Insurance Company

Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402

Administrative Office:

[Post Office Box 9000]

[Coppel, Texas 75019-9000]

Phone: [1-800-678-6227]

NAME CHANGE

[The name of the insured on the above referenced policy has been changed to _____.]

OWNERSHIP CHANGE

[The Ownership of the above referenced policy has been changed from _____ to _____.]

INCREASE/DECREASE

[The Face Amount on the above referenced policy has been [increased] [decreased] from _____ to _____.]

The new _____ premium is \$_____.]

RATE CLASS CHANGES

[The Premium Class/Rate Class on the above referenced policy has been changed to _____.]

The new _____ premium is \$_____.]

RIDER DELETION TO POLICY

[The _____ Rider has been deleted from the above referenced policy.]

The new _____ premium is \$_____.]

[The _____ Rider has been deleted from the above referenced policy with no change in premium.]

CHANGE TO RIDER

[_____, related to the insured as _____, born MMDDYY, has been [added to] [deleted from] the existing _____ rider on the above referenced policy.]

The new _____ premium is \$_____.]

PREMIUM CHANGE

[The premium for the above-referenced policy has changed to \$_____ due to _____.]

BIRTH DATE CORRECTION

[The insured's date of birth on the above referenced policy has been corrected to _____.]

ADDING A PERSON

[_____, _____ of the Insured, is hereby added as a Covered Person on the above referenced policy with no change in premium.]

[_____, _____ of the Insured, is hereby added as a Covered Person on the above referenced policy. The new _____ premium is \$_____.]

DELETING A PERSON

[_____, _____ of the Insured, no longer qualifies as a Covered Person and is hereby deleted. The new _____ premium is \$_____.]

POLICY PROVISION CHANGE

[[Item ____ of] the provision of the policy entitled _____ is hereby deleted and replaced by the following:]

[The following provision has been added to your policy.]

[INDIVIDUAL TERM LIFE INSURANCE APPLICATION]

Provident Life and Accident Insurance Company
 Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402
 Administrative Office:
 [Post Office Box 9000]
 [Coppell, Texas 75019-9000]
 Phone: [1-800-678-6227]

PART I

INSTRUCTIONS:

- Check for service desired.
- Indicate to what address items should be returned.
- Mail form (and policy if required) to Servicing Office.
- For Change of Beneficiary or Owner, complete a separate form.

SIGNATURE REQUIREMENTS:

- Insured, if age 16 or older.
- Owner, if other than the Insured.
- Assignee, if policy is assigned.
- Corporate officer with title, if policy is corporate-owned.

Policy Number: 1234567		Proposed Insured (first, middle, last): Jane R. Doe			
Address (Proposed Insured) 123 Main Street, Anytown, USA 99999		Date of Birth January 1, 1950		Gender	
		Place Anytown, USA		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	
SSN* 123-45-6789					
Owner (if other than insured)	Relationship	Address	City	State	Zip Code
Phone Number of Proposed Insured and Owner (if other than insured):					
Beneficiary	Relationship	Address	City	State	Zip Code
Contingent Beneficiary	Relationship	Address	City	State	Zip Code
Return all items to: <input checked="" type="checkbox"/> Owner <input type="checkbox"/> General Agency <input type="checkbox"/> Other (specify)					

**This application will not be processed without a valid Insured's Social Security Number (SSN) & Owner's SSN or Tax ID Number.*

Do you have any existing life insurance or annuity policies?	
<input type="checkbox"/> No <input type="checkbox"/> Yes If so, provide company name and policy number(s):	
Company Name: _____	Policy Number(s) : _____
Will this policy replace or change any existing life insurance or annuity policy?	
<input type="checkbox"/> No <input type="checkbox"/> Yes If so, provide company name and policy number(s):	
Company Name: _____	Policy Number(s) : _____

BILLING INSTRUCTIONS:

MODE: Annual Semi-Annual Quarterly Monthly Non-bill BILLING TYPE: Direct List bill PAC Government Allotment

Payor (if other than Owner) John Doe	Relationship to Owner and Insured Parent
Payor Address and Phone Number Same as above	

SPECIAL INSTRUCTIONS:

PART II – Application For:

Policy Number _____

- Term Life Policy: Complete Part II Below, Date & Sign Application**
- Term Life Reentry or Exchange: Complete Part II Below, Date & Sign Application**
- Increase – Complete Part II Below, Date & Sign Application**
- Decrease – SKIP Questions 6 through 18 Below, Date & Sign Application****
- Rate Class Change - Complete Part II Below, Date & Sign Application**
- Reinstatement – Complete Part II Below, Date & Sign Application**

****Questions 6 through 18 are not required for benefit decreases.**

Print first name, middle initial, and last name.	<u>Date of Birth</u>	Age Nearest Birthday	State of Birth	Sex	<u>Height</u>	<u>Weight</u>
	Mo Day Yr				Ft In	Now Yr ago
1. a. Proposed Insured: Jane Doe	01 01 50	50	IL	F	5 9	125 125
b. Second Proposed Insured:						
2. Proposed Insured's Occupation:	Occupational Duties:					

3. Riders Available (If checked below)***	Elect Coverage	Delete	Increase	Decrease	New Account
<input type="checkbox"/> Accidental Death & Dismemberment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> Waiver of Premium for Total Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> Other Insured Term Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> Children's Term Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$

*****For purposes of Term Life Reentry, Exchange or Reinstatement, you may only elect Riders that were included in your original Term Life Policy**

Complete for Other Insured Term Rider or Children's Term Rider.

Print first name, middle initial, and last name.	Relationship To Proposed Insured	<u>Date of Birth</u>	Age Nearest Birthday	State of Birth	Sex	<u>Height</u>	<u>Weight</u>
		Mo Day Yr				Ft In	Now Yr ago
4. a. John Doe	Spouse						
b. Sally Doe	Child						
c. Tommy Doe	Child						

Beneficiary Designation for Other Insured Rider (if applicable)	Relationship	Address	City	State	Zip Code
Beneficiary Designation for Children's Term Rider (if applicable)	Relationship	Address	City	State	Zip Code

5. Does any person proposed for coverage currently use any tobacco product?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If "YES", what form of tobacco product?**** <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine Patch/Gum Name: _____ <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine Patch/Gum Name: _____
Has any person proposed for coverage ever used any tobacco product?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If "YES", what form of tobacco product?**** <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine Patch/Gum Name: _____ <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine Patch/Gum Name: _____ What date were tobacco products last used?**** Name: _____ Date: _____ Name: _____ Date: _____

******Tobacco questions must be answered for the Proposed Insured and each person proposed for coverage under the Other Insured Term Rider. If responding on behalf of more than 2 proposed insureds, include additional information in the comment section on page 4,**

PART II – Continued

Give details in “Comments” section following the questions for any ‘YES’ answers to questions 4 through 18.

6. Within the past 5 years, has any person proposed for coverage:	
a. Been treated, examined or advised by member of the medical profession?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
b. Been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c. Been an inpatient or outpatient in a hospital, clinic or medical facility, or any similar entity?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
d. Had any surgical operations or procedures?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
e. Had diagnostic tests such as: an electrocardiogram (EKG) or X-ray, except those related to the Human Immunodeficiency Virus (AIDS virus)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
f. Made a claim for or received benefits or compensation for any injury, sickness, disability or impaired condition. <i>If “YES”, provide the date claim filed, type of benefits claimed, amounts and dates of payments received, contact information for the payor of the benefits, type of injury, sickness, disability or impaired condition, duration of these, and contact information for treating physician.</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
g. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home? <i>If “YES”, provide explanation of inability or confinement; name, address and telephone number of medical professional or facility consulted; diagnosis; treatment prescribed; medications prescribed; date of onset and recovery.</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. Has any person proposed for coverage ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:	
a. Any disease or disorder of the brain or nervous system, including but not limited to, severe headaches, fainting spells, dizziness, vertigo, syncope, epilepsy, nervousness, paralysis, mental disorder or depression?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b. Any disease or disorder of the heart, blood vessels or circulatory system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c. Any disease or disorder of the respiratory system, including but not limited to, tuberculosis, asthma, pleurisy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
d. Any disease or disorder of the stomach, liver, intestines, rectum, gall bladder, pancreas, spleen or abdominal organs?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
e. Any disease or disorder of the genito-urinary organs, including but not limited to, albumin, pus, blood or sugar in urine, urinary stone, or other disease of the kidneys, bladder or prostate, the reproductive organs?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
f. Any disease or disorder of the muscles, joints or skeletal system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
g. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
h. Any disease or disorder of the blood, skin, thyroid, lump or other glands?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
i. Rheumatic or other fever, diabetes, syphilis, gout, arthritis or goiter?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
j. Hernia or rupture, hemorrhoids or varicose veins?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
k. Any psychiatric or mental health disorder or disease?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
l. Any gynecological disorders or diseases?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
m. Any cancer, tumor, cyst or nodule?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
n. Any sexually transmitted disorders or diseases?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
o. Any disorders or diseases of the immune system except those related to the Human Immunodeficiency Virus (AIDS virus)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8. Has any person proposed for coverage been:	
a. Diagnosed or treated by a member of the medical profession for specified symptoms such as: immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi’s Sarcoma or Pneumocystis Carinii Pneumonia?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b. Diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9. Is any person proposed for coverage now pregnant? - <i>If “YES”, provide the child’s expected due date in “Comments”.</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10. Is any person proposed for coverage now under medical treatment, taking any prescription drugs or on a prescribed diet?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
11. Has any person proposed for coverage any intention to travel or reside outside the United States or Canada within the next two years?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any person proposed for coverage ever flown, or intends within the next two years to fly, other than as a fare paying passenger on a scheduled airline?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
13. Has any person proposed for coverage engaged in, or intend to engage in, underwater diving, hang gliding or parachuting, mountain or rock climbing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

14. Has any person proposed for coverage engaged in, or intend to engage in, competitive racing of any kind?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
15. Has a proposed insured ever:	
a. Used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, marijuana, or other habit forming drugs, except as prescribed by a physician;	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b. Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs; or	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c. Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16. Has any person proposed for coverage:	
a. Had a driver's license suspended or revoked?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b. Plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of alcohol or any drug?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c. Within the last 5 years, plead guilty to or been convicted of any moving violation or been involved in any accident in which the proposed insured was found to be at fault?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
17. Has any person proposed for coverage ever plead guilty to or been convicted of a felony or misdemeanor or do they have such charge currently pending against them?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
18. Does any person proposed for coverage have a parent or sibling diagnosed or treated by a member of the medical profession for certain conditions, such as heart or vascular disease, cancer, diabetes, high blood pressure, kidney disease, attempted suicide or mental illness? <i>If "YES", provide details below.</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Family Member	Age(s) (if living)	Condition Treated	Age(s) at Death	Cause of Death
Father	77	Heart Disease		
Mother	73	Cancer		
Sister	54	Diabetes		
Brother	47	High Blood Pressure		
Sister	45	Kidney Disease		

COMMENTS:

If you answered "YES" to any of questions shown above, list the question number and item(s) that you are referring to, dates/duration, diagnosis, physician name and address, phone number & name of the health care facility.

6a. Routine Physical – September, 2008; Dr. George Smith, 444 Main St., Anytown, USA 00000
11. Family vacation to Cancun, Mexico

HOME OFFICE CHANGES:

This section is for Home Office use only and may include amendments, corrections or additions. Any change in plan of insurance, amount, age at issue, gender, class or benefits shall require completion of a new application.

IMPORTANT NOTICES (Please Read carefully)

For purposes of this application Provident Life and Accident Insurance Company will be referred to as “the Company”, “we”, “us” or “our”.

NOTICE TO UNITED STATES RESIDENTS UNDER FAIR CREDIT REPORTING ACT

We would like to explain a part of our underwriting process that is frequently misunderstood. You are entitled to know that, as part of our routine selection procedure, we may request an investigative consumer report (“report”) concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured.

If we request a report and you want: 1) additional information about the nature and scope of the report; or 2) to be interviewed in connection with the report; or 3) to receive a copy of the report; please make a written request to the **Servicing Office, [insert address]**. Please include the name of your agent as well as your own full name, date of birth and return address.

In order to provide the best possible products on the most favorable basis, it is necessary for us to be somewhat selective in issuing our policies. We sincerely believe that the consumer investigative report is an essential and proper tool to assist us in meeting these mutual objectives. We will do our best to serve you both now and in the future. Please call us any time at our toll-free number: **[insert toll free number]**. You may obtain a written summary of your rights under the Fair Credit Reporting Act online at www.ftc.gov/credit or by writing to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Avenue, NW, Washington, DC 20580.]

NOTICE REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 886 346-3642). If you question the accuracy of the information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.]

FRAUD NOTICES

[For Residents of the District of Columbia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[For Residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[For Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[For Residents of New Mexico: 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 civil fines and criminal penalties.]

[Notice For Residents of All Other States: 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 may be guilty of a crime and may be subject to fines and confinement in prison.]

AGREEMENT

I declare to the best of my knowledge and belief the foregoing statements and answers are complete and true and have been made to induce the Company to issue, change or reinstate the above referenced policy. No information will be considered to have been given to the Company unless it is included herein or on a Supplemental Underwriting Questionnaire.

I agree that the policy shall not be changed until the Company has received payment of all premiums in arrears and has formally approved the application. I further agree to accept a return of any payments made in connection with this application for change or reinstatement should the Company decline any policy change or reinstatement.

I further agree that if the Company approves this application for issue, change or reinstatement, such approval shall be based upon the above statements and answers, which shall be deemed to be representations and not warranties. I further agree as an express condition of such change, that if any such representation is untrue in whole or in part, and is material, the Company shall be under no liability by reason of any change or reinstatement, except to return all premiums paid in connection with and subsequent to any such change or reinstatement; but on the condition that any change or reinstatement shall be incontestable after the same period following any such change or reinstatement and with the same conditions and exceptions as provided in the policy with respect to the incontestability thereof. It is understood that, unless otherwise provided, the reinstatement of a policy reinstates interests of any assignees, beneficiaries or owners.

I understand that if making a policy change, unless the change will be to the same plan of insurance, no disability benefits will be allowed for any condition existing at the present time. If the above policy is to be surrendered with this service request, I hereby surrender the policy for cancellation and agree that this request together with the application for the original policy shall constitute the application for any new policy and that the original application shall be changed only to the extent provided by this service request.

I request that all transactions marked above be completed by the Company and agree on behalf of myself and all of my heirs, beneficiaries, assignees and any others claiming under the above policy to release, indemnify and hold the Company harmless from any liability incurred because of completing the above transactions.

I expressly warrant that all persons signing below are of legal age and that no proceedings in bankruptcy are pending against any of them.

[AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

This authorization complies with the HIPAA Privacy Rule and applies to each undersigned. Please read carefully and sign below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers"), to disclose the entire medical record and any other protected health information concerning me or me and my minor children to the Company and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

I also authorize any insurance or reinsuring company, the MIB, Inc., employer or any other organization, institution, person, consumer reporting agency, or insurance support organization that has any personal (medical or non medical) information of mine or my minor children to release such information, including the entire medical record without restriction if requested, to the Company, its agents, employees and representatives.

The Company may use and disclose information received under this Authorization to: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health insurance.

This authorization shall remain valid for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original.

I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at [insert address]. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application, or, if coverage has been issued, may not be able to make any benefit payments. I have received a copy of this Authorization, which I have signed and will retain for my records.]

I have read this Individual Term Life Insurance Application and all notices included herein, and all statements and answers are true and complete to the best of my knowledge and belief.

Dated at (City and State) Anytown, USA, this 12th Day of September, 2003.

Proposed Insured (if age 16 or over) or Legal Representative & Legal Representative's Authority / Relationship to Proposed Insured

Owner (if not Proposed Insured) and relationship & Title of Officer Signing as Owner if Owner is Corporation, Partnership, Trust

Witness (not related) or Agent

Assignee

Telephone Number of Proposed Insured (day) (555) 555-9999 (night) (555) 555-0001

An Agent does not have the Company's authorization to accept risk, approved evidence of insurability, or make, void, waive or change any conditions or provisions of this application or policy.

Servicing Agent's Name	Agency Code	Agent Code	Agent's Phone Number
John Smith	00001	0000123	555-555-1234

Will this policy replace or change any existing life insurance or annuity policy?

No Yes

Agent Signature

IMPORTANT NOTICES

Please Retain for your records. This is your copy of the Important Notices appearing on the Individual Term Life Insurance Application Form ICC 08 – RTL App 1.0

For purposes of this application Provident Life and Accident Insurance Company will be referred to as “the Company”, “we”, “us” or “our”.

NOTICE TO UNITED STATES RESIDENTS UNDER FAIR CREDIT REPORTING ACT

We would like to explain a part of our underwriting process that is frequently misunderstood. You are entitled to know that, as part of our routine selection procedure, we may request an investigative consumer report (“report”) concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured.

If we request a report and you want: 1) additional information about the nature and scope of the report; or 2) to be interviewed in connection with the report; or 3) to receive a copy of the report; please make a written request to the **Servicing Office, [insert address]**. Please include the name of your agent as well as your own full name, date of birth and return address.

In order to provide the best possible products on the most favorable basis, it is necessary for us to be somewhat selective in issuing our policies. We sincerely believe that the consumer investigative report is an essential and proper tool to assist us in meeting these mutual objectives. We will do our best to serve you both now and in the future. Please call us any time at our toll-free number: **[insert toll free number]**. You may obtain a written summary of your rights under the Fair Credit Reporting Act online at www.ftc.gov/credit or by writing to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Avenue, NW, Washington, DC 20580.]

NOTICE REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 886 346-3642). If you question the accuracy of the information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.]

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

This authorization complies with the HIPAA Privacy Rule and applies to each undersigned. Please read carefully and sign below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, (“My Providers”), to disclose the entire medical record and any other protected health information concerning me or me and my minor children to the Company and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children’s protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

I also authorize any insurance or reinsuring company, the MIB, Inc., employer or any other organization, institution, person, consumer reporting agency, or insurance support organization that has any personal (medical or non medical) information of mine or my minor children to release such information, including the entire medical record without restriction if requested, to the Company, its agents, employees and representatives.

The Company may use and disclose information received under this Authorization to: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health insurance.

This authorization shall remain valid for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original.

I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at **[insert address]**. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application, or, if coverage has been issued, may not be able to make any benefit payments. I have received a copy of this Authorization, which I have signed and will retain for my records.

[RE-ENTRY / EXCHANGE APPLICATION]

Provident Life and Accident Insurance Company
 Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402
 Administrative Office:
 [Post Office Box 9000]
 [Coppell, Texas 75019-9000]
 Phone: [1-800-678-6227]

Policy Number: 12345678		Effective date of Policy being exchanged: April 1, 1998			
Proposed Insured (first, middle, last) John Doe		Date of Birth January 1, 1973		Sex	
		Place Indiana		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	
SSN* 123-45-6789					
Address (Proposed Insured) 1234 North Main Street		City Anytown		State USA	
				Zip Code 98765	
Owner (if other than insured)	Relationship	Address	City	State	Zip Code
					SSN*
Phone Number of Proposed Insured and Owner (if other than insured): 260-999-9999					
Beneficiary Jane Doe	Relationship Spouse	Address Same as above		City	State
				Zip Code	
Contingent Beneficiary	Relationship	Address	City	State	Zip Code
Return all items to: <input checked="" type="checkbox"/> Owner <input type="checkbox"/> General Agency <input type="checkbox"/> Other (specify)					

**This application will not be processed without a valid Insured's Social Security Number (SSN) & Owner's SSN or Tax ID Number.*

Current Face Amount: <u> \$10,000 </u>	If you are requesting an increase in your Face Amount, the following conditions apply: 1) your current policy must allow for Increases in coverage; 2) you must submit satisfactory evidence of insurability; and 3) the increase in coverage must be underwritten in accordance with our current underwriting rules and practices.
Face amount Requested: <u> \$10,000 </u>	
The Riders checked below are available for reentry/exchange.	
Indicate your acceptance by initialing the box(es) below.	
<input type="checkbox"/> Other Insured Rider: _____ Face amount: _____	<input type="checkbox"/> I elect to convert this Rider.
<input type="checkbox"/> Children's Term Rider: _____ Face amount: _____	<input type="checkbox"/> I elect to convert this Rider.
<input type="checkbox"/> Waiver of Premium Rider:	<input type="checkbox"/> I elect to convert this Rider.
<input type="checkbox"/> *Accidental Death & Dismemberment Rider Principal sum: _____	<input type="checkbox"/> I elect to convert this Rider.
Beneficiary Designation for Other Insured Rider (if applicable) Relationship Address City State Zip Code	
Beneficiary Designation for Children's Term Rider (if applicable) Relationship Address City State Zip Code	
Comments:	

BILLING INSTRUCTIONS:

MODE: Annual Semi-Annual Quarterly Monthly Non-bill

BILLING TYPE: Direct List bill Automatic Bank Draft (requires completion of Bank Authorizaiton Form) Government Allotment

Payor (if other than Owner)	Payor's Social Security Number
Payor Address and Phone Number	Relationship to Owner and Insured

FRAUD NOTICES

[For Residents of the District of Columbia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[For Residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[For Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[For Residents of New Mexico: 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 civil fines and criminal penalties.]

[Notice For Residents of All Other States: 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 may be guilty of a crime and may be subject to fines and confinement in prison.]

AGREEMENT

I declare to the best of my knowledge and belief the foregoing statements and answers are complete and true.

I agree that if Provident Life and Accident Insurance Company ("the Company") accepts this application, such approval shall be based upon the above statements and answers, which shall be deemed to be representations and not warranties.

I further agree that insurance will not take effect until the application is approved and accepted by the Company, and at least the first modal premium has been paid in full.

I request that this transaction be completed by the Company and agree on behalf of myself and all of my heirs, beneficiaries, assignees and any others claiming under the above policy to release, indemnify and hold the Company harmless from any liability incurred because of completing the above transaction.

I expressly represent that all persons signing below are of legal age and that no proceedings in bankruptcy are pending against any of them.

Dated at (City and State) _____, this _____ Day of _____.

Proposed Insured (if age 16 or over) or Legal Representative &
Legal Representative's Authority/Relationship to Proposed Insured

Witness (not related) or Agent

Owner (if not Proposed Insured) and relationship & Title of
Officer Signing as Owner if Owner is Corporation, Partnership, Trust

Assignee

Servicing Agent's Name	Agency Code	Agent Code
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Provident Life and Accident Insurance Company
Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402
Administrative Office:
[Post Office Box 9000]
[Coppell, Texas 75019-9000]
Phone: [1-800-678-6227]

Proposed Insured John Doe

Policy Number 12345678

I request that the application dated MMDDYY be amended as follows:

(Example) This policy has been issued with a face amount of \$100,000.00

Each person signing this Application Amendment agrees that all representations made in this form are true and complete to the best of that person's knowledge and belief on the date signed.

It is agreed that this amendment shall form a part of the application and any policy issued thereunder and it shall be binding on every person who shall have or claim any interest under said policy.

Dated at (City and State) Anytown, USA, this 12th Day of September, 2008.

Proposed Insured (if age 16 or over) or Legal Representative &
Legal Representative's Authority / Relationship to Proposed

Insured

Owner (if not Proposed Insured) and relationship

Witness (not related) or Agent

Assignee

SUPPLEMENTAL UNDERWRITING QUESTIONNAIRE

Provident Life and Accident Insurance Company

Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Phone: [1-800-678-6227]

To be completed in full by the Proposed Insured: John Doe

Policy Number: 1234567

This Supplemental Underwriting Questionnaire will become part of your Individual Term Life Insurance Application.

Attending Physician Questionnaire

Certain medical factors play an important role in our evaluation of your application. Therefore, we require further medical information from the physician who treated you or is currently treating you for _____. Please provide this physician's name, address and telephone number below. Upon receipt of this information, we will contact the physician to request the necessary records.

Doctor's Name

Address

(_____) _____
Telephone

Alcohol Questionnaire

- How often do you drink currently?
Daily ____ Weekly ____ Less than Weekly ____ None ____
- How many drinks (glasses, bottles, cans) do (did) you consume at a time? _____
- What types of alcohol do (did) you drink? Wine ____ Beer ____ Hard Liquor ____
- When was the last time you had 5 or more drinks on one occasion (month/year): ____/____
- Has a counselor or medical professional ever told you to reduce or stop drinking alcoholic beverages? Yes ____ No ____ If yes, please provide details:

- Have you ever been treated or hospitalized for alcohol use? Yes ____ No ____ If yes, when and where:

7. Have you been a member of an alcohol support group? Yes ___ No ___ If yes, please provide the name of the group and the last meeting attended:

8. Have you ever had any relapses since treated? Yes ___ No ___ If yes, what was the date of your last relapse (month/year)? ____/____/____

9. Have you ever been arrested because of excessive alcohol use or been charged with driving under the influence of alcohol? Yes ___ No ___ If yes, please provide details and dates (month/year):

Aviation Questionnaire

A. Flying Time (Please indicate hours as pilot, co-pilot, crew member, or passenger with duties aboard aircraft)

1. Flying for Pay

	1-2 Years Ago	Past 12 Months	Next 12 Months
Scheduled passenger airline			
Employer owned aircraft for employee travel			
Other freight or passenger service			
Crop dusting or aerial spraying			
Flight Instructor			
Other: _____			

2. Not flying for Pay

	1-2 Years Ago	Past 12 Months	Next 12 Months
Pleasure			
Personal business transportation			
Student Pilot			
Other: _____			

3. Total number of solo hours flown as a pilot: _____ Date of last flight (month/year): ____/____/____

B. Licenses and Certificates

- 1. What type of certificate do you now have? Student – date obtained (month/year): ____/____
Private _____
Commercial ____ ATR ____ Other _____
- 2. Do you have an Instrument Flight Rating (IFR)? Yes ____ No ____
a) How many hours of instrument flight time have you logged in the past 12 months? _____
- 3. What other ratings do you have? _____

C. Flying Details

- 1. In what types of aircraft do you fly – provide make and model _____
Description: Fixed-wing ____ Rotorcraft ____ Piston ____ Turboprop ____ Jet ____
Single-engine ____ Multi-engine ____ Seating capacity _____
- 2. Have you ever flown the following types of aircraft, and/or do you intend to fly any of them in the future? Yes ____ No ____ If yes, which ones: Prototype ____ Experimental ____ Homebuilt/kit ____
Ultralight ____ Hang glider ____ Balloon ____ Sailplane ____
- 3. Do you participate in aerobatic flying? Yes ____ No ____ If yes, please provide details and number of hours per year: _____

- 4. How much of your flying time is with a qualified co-pilot? _____
- 5. Have you ever had an aircraft accident, or been grounded, fined, or reprimanded for violation(s) of air regulation? Yes ____ No ____ If yes, please provide details: _____

- 6. Have you flown, or do you intend to fly outside the United States? Yes ____ No ____ If yes, when and where? _____

Avocation Questionnaire

A. Mountain Climbing

- 1. Check whichever ones apply:
Mountain Climb _____, Hike _____, Trail Blaze, _____ Rock Climb _____
I have a professional climber status _____ I am an amateur climber _____
- 2. Heights that I climb :
I do not climb mountains/rocks _____, I do climb but: under 13,000 ft _____, over 13,000 ft _____

3. Location of climbs (Past & Future):

US only (lower 48 states) _____, Africa _____, Alps _____, Andes _____,
Alaska & Canada, excluding Mt McKinley _____, Mt McKinley _____, Brooks Range _____,
Himalayas _____, Other _____ Where _____

4. Experience:

I've climbed for under 2 yrs _____ more than 2 yrs _____

Total Number of climbs : Less than 6 _____, more than 6 _____

5. Date of last climb (month/year): _____

B. Sky Diving

1. Check whichever ones apply:

Amateur _____ Professional _____ Instructor _____ Stunt _____ Other _____

Give details of Other _____

2. Number of jumps per year : 0-50 _____ 51-100 _____ 101-200 _____ 201+ _____

3. Do you jump: Static Line _____ Free Fall _____ Exhibition _____ Competition _____

4. Date of last jump (month/year): _____

C. Ballooning

1. Check whichever ones apply:

Tethered _____ Free Flight _____

Record Attempts _____ Ocean Crossing _____ Mountain Crossing _____

Other _____ Give details to Other _____

2. Experience: 0 -34 hours _____ 35+hours _____

3. Date of last flight (month/year) _____

D. Hang Gliding

1. Are you a USGH member? Yes _____ No _____

2. Are you an amateur status? Yes _____ No _____

3. Are you an Instructor? Yes _____ No _____

4. Do you participate in record attempts? Yes____ No ____

5. Do you use powered Hang Gliders? Yes____ No ____

If No, describe the gliders that you use _____

6. Date of last flight (month/year):_____

7. How many times a year do you glide_____

E. Ultralight

1. Are you a fully licensed airplane pilot? ___Yes ___ No

2. The ultralight I fly is: Commercially produced _____ Homebuilt _____ and/or
an Experimental craft_____

3. I fly at altitudes of: _____under 3000 feet _____over 3000 feet

4. Date of last flight (month/year):_____.

F. Other Sports or Avocations

Describe:_____

1. Experience: Less than 1 yr_____ 1-2 yrs_____ More than 2 yrs_____

2. Frequency: _____times per year

3. Date of last activity (month/year): _____

4. Location:_____

5. Certificate or license:_____ Clubs or Associations_____

6. Additional Details

Drug Questionnaire

- | | | |
|--|-------|-------|
| 1. In the past 10 years, have you used: | Yes | No |
| a) Cocaine or other stimulants? | _____ | _____ |
| b) Marijuana | _____ | _____ |
| c) LSD, or other Hallucinogenics? | _____ | _____ |
| d) Heroin, Demerol or other narcotics? | _____ | _____ |
| e) Barbiturates, sedatives or tranquilizers? | _____ | _____ |

2. List below the drugs taken and the periods of use:

Drugs	Dates Used		How often
	From	To	

3. Date of last drug use (month/year): _____ / _____

4. Have you ever been treated or hospitalized for drug use? Yes ____ No ____ If yes, when and where?

5. Have you ever acquired a disease secondary to drug use? Yes ____ No ____ If yes, what disease and when was it diagnosed? _____

6. Have you ever been a member of a drug rehabilitation support group? Yes ____ No ____ If yes, please provide the name of the group and the last meeting attended? _____

7. Have you ever been arrested because of drug use (including motor vehicle violations)?
Yes ____ No ____ If yes, please provide details and dates (month/year): _____

Financial Questionnaire

1. Please complete the financial worksheet below. This information is used as part of the evaluation of your life insurance application and is kept strictly confidential.

Assets		Liabilities	
Cash on Hand		Accounts Payable	
Personal Residence		Personal Loans	
Stocks		Mortgages	
Bonds		Other Debts	
Mutual Funds		Total Liabilities	\$
Personal Property		Net Worth (Total Assets & Total Liabilities)	\$
Accounts Receivable & Notes			
Other Real Estate		Earnings	
Business Ownership		Annual Earned Income	
Other Assets		Passive Income (Investments, rent, etc.)	
Total Assets	\$	Total Annual Income	\$

2. Are you the subject of any liens, legal judgements or pending lawsuits? Yes ____ No ____
3. Have you undergone bankruptcy in the past five years? Yes ____ No ____ If yes, has the bankruptcy been satisfied? Yes ____ No ____
4. How much life insurance do you have (all policies totaled)? \$ _____

Foreign Travel/Residence/Citizenship Questionnaire

A. US or Canadian citizens traveling to or residing in a foreign country

1. Countries to which you have traveled or resided in the last 5 years: _____

- a) Reason for travel/residence: Vacation ____ Business ____ Other _____

- b) Length of stay: _____
- c) Location (cities, region, etc.): _____

2. Countries to which you plan to visit/reside in the next 2 years? _____

 a) Reason for travel: Vacation _____ Business _____ Other _____

 b) Planned date of departure (month/year): _____/_____
 c) Planned length of stay: _____
 d) Location (cities, region, etc.) _____
3. Do you have family members who reside outside of the US and Canada Yes ___ No ___
 If yes , Where _____

B. Foreign Nationals visiting/residing in US or Canada

1. Of which country or countries are you a citizen? _____
2. How long have you been in the US or Canada? _____
3. What type of visa or alien registration card do you have? _____
4. Do you plan to become a citizen of the US or Canada? Yes ___ No ___ If yes, when? _____

5. If married, is your spouse a US or Canadian citizen? Yes ___ No ___
6. Do you plan to visit/reside in countries other than the US or Canada in the next 5 years?
 Yes ___ No ___ If yes, please provide the purpose and planned length of stay: _____

7. Do you have family members who reside outside of the US and Canada Yes ___ No ___
 If yes , Where _____

Tobacco Use Questionnaire

1. Do you currently use any of the following tobacco products?

	Yes	No	Number or Quantity Used Per Day
Cigarettes			
Cigars			
Pipe			
Chewing tobacco			
Other:			
_____			_____
_____			_____
_____			_____
_____			_____

2. Have you used any of these tobacco products in the past?

	Yes	No	Number or Quantity Used Daily	Date Last Used (month/year)
Cigarettes				____/____
Cigars				____/____
Pipe				____/____
Chewing tobacco				____/____
Other: _____ _____ _____ _____				____/____ ____/____ ____/____ ____/____

3. Are you currently using a prescription or over-the-counter product to help you stop using tobacco?
 Yes ____ No ____ If yes, please provide the following information:

Name of Product	Length of time you have used product(s)
_____	_____
_____	_____
_____	_____

I represent that all statements and answers made in all parts of this application are complete and true to the best of my knowledge and belief. I agree that this questionnaire shall form a part of my Individual Term Life Insurance Application.

Proposed Insured

Date

STATEMENT OF INSURABILITY

Provident Life and Accident Insurance Company

Home Office: 1 Fountain Square, Chattanooga, Tennessee 37402

Administrative Office:

[Post Office Box 9000]

[Coppell, Texas 75019-9000]

Phone: [1-800-678-6227]

This statement has been completed as a condition of the delivery and acceptance of the Individual Term Life Insurance Application completed on the following policy:

Policy No. 1234567

Insured John Doe

Since the date of application completed on:

08/01/08

(date mm/dd/yy)

Has any person proposed for coverage or reinstatement of coverage:

1. had a change in health, Yes No
2. made an application for insurance which has been declined, postponed or modified, Yes No
3. made an application for life insurance with any other company, Yes No
4. consulted or been examined by a physician or practitioner or been referred to another physician or had any known indication of any medical condition which was not indicated on the original application as mentioned above. Yes No

If you have answered YES to any of the above statements, please provide full details below. In regard to #4 above, please provide dates, diagnosis, doctor's complete name, address and phone number.

I represent that all statements and answers made above are complete and true to the best of my knowledge and belief. I agree that this Statement of Insurability shall form a part of my Individual Term Life Insurance Application.

John J. Doe

Insured or Proposed Insured

09 / 15 / 2008

Date

SERFF Tracking Number: CMPL-126055793 State: Arkansas
 Filing Company: Provident Life and Accident Insurance Company State Tracking Number: 41819
 Company Tracking Number: PLAIC ITL 2-2009
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: PLAIC ITL 2-2009
 Project Name/Number: PLAIC ITL 2-2009/PLAIC ITL 2-2009

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
	RATES	PTL2.0	New		PCTR2.0 _Rates_and_act_ memo.pdf

CHILDREN'S TERM RIDER

Provident Life and Accident Insurance Company
Statement of Actuarial Basis
Form PCTR2.0

I. PRODUCT DESCRIPTION

This rider provides for level term insurance on each of the insured's children, aged 15 days to 18 years. The rider expires on the policy anniversary on which the insured has attained age 65. Insurance on any covered child terminates on the policy anniversary on which the child turns age 25.

Premiums are guaranteed.

The minimum rider coverage amount is \$5,000.

II. PREMIUM

The premium is increased by the rider. The amount of the increase is equal to \$6.00 times the number of units (1 unit = \$1,000). The premium is not dependent upon the number of children covered.

III. MINIMUM NONFORFEITURE VALUES

This is to certify that this rider is in compliance with the NAIC Standard Nonforfeiture Law for Life Insurance, Model #808. This rider does not require nor does it provide any nonforfeiture values, because:

- a. For issue ages 5 to 18, it provides for a term policy of uniform amount, no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of 20 years or less, expiring before the age of 71. For these issue ages, the rider is excepted under Section 9E of the Standard Nonforfeiture Law
- b. For issue ages 0 to 4, it provides for no guaranteed nonforfeiture or endowment benefits, and would not provide minimum cash values exceeding 2.5% of the amount of insurance in any rider year. A detailed proof of this, for males and females, using 2001 CSO Sex-Distinct Mortality and 5% interest, is attached.

IV. RESERVES

The only reserve for this rider is the unearned premium, since the slope of mortality is anticipated to be level with the premiums.

V. COMPACT STANDARDS FOR ACTUARIAL SUBMISSION

Per the Standards for Additional Term Life Insurance Benefits, Additional Submission Requirements, Subsection (4).

- (a) Section III, above, demonstrates that no nonforfeiture values are required
- (b) No form provisions affect nonforfeiture values
- (c) This form has no guaranteed maximum cost of insurance benefits, per se, as it is a fixed premium product.
- (d) Identifiable charges for this form are not subject to change
- (e) This form has no identifiable charges in the form of cost of insurance rates.
- (f) No nonforfeiture benefits are required by this form
- (g) No sample calculations are provided, since no nonforfeiture benefits are required
- (h) The certification according to the NAIC Standard Nonforfeiture Law is set forth in Section III, above
- (i) The range of issue ages and minimum benefit are set forth in Section I, above

February 18, 2009

Date



Steve Griffith, FSA, MAAA
Consulting Actuary
Griffith, Ballard and Company
100 First Avenue NE, Suite 117
Cedar Rapids, IA 52401
319-896-5960

Provident Life and Accident Insurance Company
Children's Term Rider Form PCTR2.0
Demonstration that Cash Values are Not Required
Based upon SNF Minimums, 2001 CSO Male and Female (ALB) distinct, 5% interest

Sex	Issue Age	Policy Year	Mortality Rate	Net Single Premium	Annuity Factor	CV Exp Allow	Nonforf Premium	Minimum Cash Value
Male	0	0		6.81710	14.74314	10.57799		(10.58)
Male	0	1	0.00072	6.44259	14.44069		1.17988	(10.60)
Male	0	2	0.00046	6.30762	14.11922		1.17988	(10.35)
Male	0	3	0.00033	6.29508	13.77973		1.17988	(9.96)
Male	0	4	0.00024	6.37136	13.42194		1.17988	(9.46)
Male	0	5	0.00021	6.48129	13.04577		1.17988	(8.91)
Male	0	6	0.00021	6.59674	12.65072		1.17988	(8.33)
Male	0	7	0.00022	6.70805	12.23595		1.17988	(7.73)
Male	0	8	0.00022	6.82496	11.80034		1.17988	(7.10)
Male	0	9	0.00022	6.94774	11.34285		1.17988	(6.44)
Male	0	10	0.00023	7.06675	10.86249		1.17988	(5.75)
Male	0	11	0.00024	7.18181	10.35810		1.17988	(5.04)
Male	0	12	0.00028	7.26293	9.82876		1.17988	(4.33)
Male	0	13	0.00034	7.28856	9.27335		1.17988	(3.65)
Male	0	14	0.00040	7.25589	8.69049		1.17988	(3.00)
Male	0	15	0.00052	7.10237	8.07922		1.17988	(2.43)
Male	0	16	0.00066	6.80198	7.43809		1.17988	(1.97)
Male	0	17	0.00078	6.36705	6.76527		1.17988	(1.62)
Male	0	18	0.00089	5.80056	6.05893		1.17988	(1.35)
Male	0	19	0.00095	5.14548	5.31693		1.17988	(1.13)
Male	0	20	0.00098	4.42709	4.53722		1.17988	(0.93)
Male	0	21	0.00100	3.65210	3.71780		1.17988	(0.73)
Male	0	22	0.00101	2.82756	2.85657		1.17988	(0.54)
Male	0	23	0.00102	1.95093	1.95139		1.17988	(0.35)
Male	0	24	0.00104	1.00952	1.00000		1.17988	(0.17)
Male	0	25	0.00106	-	-		1.17988	-
Male	1	0		6.44259	14.44069	10.55768	1.17988	(10.56)
Male	1	1	0.00046	6.30762	14.11922		1.17725	(10.31)
Male	1	2	0.00033	6.29508	13.77973		1.17725	(9.93)
Male	1	3	0.00024	6.37136	13.42194		1.17725	(9.43)
Male	1	4	0.00021	6.48129	13.04577		1.17725	(8.88)
Male	1	5	0.00021	6.59674	12.65072		1.17725	(8.30)
Male	1	6	0.00022	6.70805	12.23595		1.17725	(7.70)
Male	1	7	0.00022	6.82496	11.80034		1.17725	(7.07)
Male	1	8	0.00022	6.94774	11.34285		1.17725	(6.41)
Male	1	9	0.00023	7.06675	10.86249		1.17725	(5.72)
Male	1	10	0.00024	7.18181	10.35810		1.17725	(5.01)
Male	1	11	0.00028	7.26293	9.82876		1.17725	(4.31)
Male	1	12	0.00034	7.28856	9.27335		1.17725	(3.63)
Male	1	13	0.00040	7.25589	8.69049		1.17725	(2.97)
Male	1	14	0.00052	7.10237	8.07922		1.17725	(2.41)
Male	1	15	0.00066	6.80198	7.43809		1.17725	(1.95)
Male	1	16	0.00078	6.36705	6.76527		1.17725	(1.60)
Male	1	17	0.00089	5.80056	6.05893		1.17725	(1.33)

Provident Life and Accident Insurance Company
Children's Term Rider Form PCTR2.0
Demonstration that Cash Values are Not Required
Based upon SNF Minimums, 2001 CSO Male and Female (ALB) distinct, 5% interest

Sex	Issue Age	Policy Year	Mortality Rate	Net Single Premium	Annuity Factor	CV Exp Allow	Nonforf Premium	Minimum Cash Value
Male	1	18	0.00095	5.14548	5.31693		1.17725	(1.11)
Male	1	19	0.00098	4.42709	4.53722		1.17725	(0.91)
Male	1	20	0.00100	3.65210	3.71780		1.17725	(0.72)
Male	1	21	0.00101	2.82756	2.85657		1.17725	(0.54)
Male	1	22	0.00102	1.95093	1.95139		1.17725	(0.35)
Male	1	23	0.00104	1.00952	1.00000		1.17725	(0.17)
Male	1	24	0.00106	-	-		1.17725	-
Male	2	0		6.30762	14.11922	10.55843	1.17725	(10.56)
Male	2	1	0.00033	6.29508	13.77973		1.19455	(10.17)
Male	2	2	0.00024	6.37136	13.42194		1.19455	(9.66)
Male	2	3	0.00021	6.48129	13.04577		1.19455	(9.10)
Male	2	4	0.00021	6.59674	12.65072		1.19455	(8.52)
Male	2	5	0.00022	6.70805	12.23595		1.19455	(7.91)
Male	2	6	0.00022	6.82496	11.80034		1.19455	(7.27)
Male	2	7	0.00022	6.94774	11.34285		1.19455	(6.60)
Male	2	8	0.00023	7.06675	10.86249		1.19455	(5.91)
Male	2	9	0.00024	7.18181	10.35810		1.19455	(5.19)
Male	2	10	0.00028	7.26293	9.82876		1.19455	(4.48)
Male	2	11	0.00034	7.28856	9.27335		1.19455	(3.79)
Male	2	12	0.00040	7.25589	8.69049		1.19455	(3.13)
Male	2	13	0.00052	7.10237	8.07922		1.19455	(2.55)
Male	2	14	0.00066	6.80198	7.43809		1.19455	(2.08)
Male	2	15	0.00078	6.36705	6.76527		1.19455	(1.71)
Male	2	16	0.00089	5.80056	6.05893		1.19455	(1.44)
Male	2	17	0.00095	5.14548	5.31693		1.19455	(1.21)
Male	2	18	0.00098	4.42709	4.53722		1.19455	(0.99)
Male	2	19	0.00100	3.65210	3.71780		1.19455	(0.79)
Male	2	20	0.00101	2.82756	2.85657		1.19455	(0.58)
Male	2	21	0.00102	1.95093	1.95139		1.19455	(0.38)
Male	2	22	0.00104	1.00952	1.00000		1.19455	(0.19)
Male	2	23	0.00106	-	-		1.19455	-
Male	3	0		6.29508	13.77973	10.57105	1.19455	(10.57)
Male	3	1	0.00024	6.37136	13.42194		1.22398	(10.06)
Male	3	2	0.00021	6.48129	13.04577		1.22398	(9.49)
Male	3	3	0.00021	6.59674	12.65072		1.22398	(8.89)
Male	3	4	0.00022	6.70805	12.23595		1.22398	(8.27)
Male	3	5	0.00022	6.82496	11.80034		1.22398	(7.62)
Male	3	6	0.00022	6.94774	11.34285		1.22398	(6.94)
Male	3	7	0.00023	7.06675	10.86249		1.22398	(6.23)
Male	3	8	0.00024	7.18181	10.35810		1.22398	(5.50)
Male	3	9	0.00028	7.26293	9.82876		1.22398	(4.77)
Male	3	10	0.00034	7.28856	9.27335		1.22398	(4.06)
Male	3	11	0.00040	7.25589	8.69049		1.22398	(3.38)
Male	3	12	0.00052	7.10237	8.07922		1.22398	(2.79)

Provident Life and Accident Insurance Company
Children's Term Rider Form PCTR2.0
Demonstration that Cash Values are Not Required
Based upon SNF Minimums, 2001 CSO Male and Female (ALB) distinct, 5% interest

Sex	Issue Age	Policy Year	Mortality Rate	Net Single Premium	Annuity Factor	CV Exp Allow	Nonforf Premium	Minimum Cash Value
Male	3	13	0.00066	6.80198	7.43809		1.22398	(2.30)
Male	3	14	0.00078	6.36705	6.76527		1.22398	(1.91)
Male	3	15	0.00089	5.80056	6.05893		1.22398	(1.62)
Male	3	16	0.00095	5.14548	5.31693		1.22398	(1.36)
Male	3	17	0.00098	4.42709	4.53722		1.22398	(1.13)
Male	3	18	0.00100	3.65210	3.71780		1.22398	(0.90)
Male	3	19	0.00101	2.82756	2.85657		1.22398	(0.67)
Male	3	20	0.00102	1.95093	1.95139		1.22398	(0.44)
Male	3	21	0.00104	1.00952	1.00000		1.22398	(0.21)
Male	3	22	0.00106	-	-		1.22398	-
Male	4	0		6.37136	13.42194	10.59337	1.22398	(10.59)
Male	4	1	0.00021	6.48129	13.04577		1.26396	(10.01)
Male	4	2	0.00021	6.59674	12.65072		1.26396	(9.39)
Male	4	3	0.00022	6.70805	12.23595		1.26396	(8.76)
Male	4	4	0.00022	6.82496	11.80034		1.26396	(8.09)
Male	4	5	0.00022	6.94774	11.34285		1.26396	(7.39)
Male	4	6	0.00023	7.06675	10.86249		1.26396	(6.66)
Male	4	7	0.00024	7.18181	10.35810		1.26396	(5.91)
Male	4	8	0.00028	7.26293	9.82876		1.26396	(5.16)
Male	4	9	0.00034	7.28856	9.27335		1.26396	(4.43)
Male	4	10	0.00040	7.25589	8.69049		1.26396	(3.73)
Male	4	11	0.00052	7.10237	8.07922		1.26396	(3.11)
Male	4	12	0.00066	6.80198	7.43809		1.26396	(2.60)
Male	4	13	0.00078	6.36705	6.76527		1.26396	(2.18)
Male	4	14	0.00089	5.80056	6.05893		1.26396	(1.86)
Male	4	15	0.00095	5.14548	5.31693		1.26396	(1.57)
Male	4	16	0.00098	4.42709	4.53722		1.26396	(1.31)
Male	4	17	0.00100	3.65210	3.71780		1.26396	(1.05)
Male	4	18	0.00101	2.82756	2.85657		1.26396	(0.78)
Male	4	19	0.00102	1.95093	1.95139		1.26396	(0.52)
Male	4	20	0.00104	1.00952	1.00000		1.26396	(0.25)
Male	4	21	0.00106	-	-		1.26396	-
Female	0	0		4.25357	14.76058	10.36021	1.26396	(10.36)
Female	0	1	0.00042	4.04795	14.45468		0.99005	(10.26)
Female	0	2	0.00031	3.94157	14.13180		0.99005	(10.05)
Female	0	3	0.00023	3.90955	13.79156		0.99005	(9.74)
Female	0	4	0.00020	3.90581	13.43383		0.99005	(9.39)
Female	0	5	0.00019	3.91184	13.05800		0.99005	(9.02)
Female	0	6	0.00018	3.92814	12.66318		0.99005	(8.61)
Female	0	7	0.00019	3.93529	12.24866		0.99005	(8.19)
Female	0	8	0.00021	3.92288	11.81358		0.99005	(7.77)
Female	0	9	0.00021	3.90985	11.35664		0.99005	(7.33)
Female	0	10	0.00021	3.89616	10.87676		0.99005	(6.87)
Female	0	11	0.00022	3.87182	10.37288		0.99005	(6.40)

Provident Life and Accident Insurance Company
Children's Term Rider Form PCTR2.0
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Sex	Issue Age	Policy Year	Mortality Rate	Net Single Premium	Annuity Factor	CV Exp Allow	Nonforf Premium	Minimum Cash Value
Female	0	12	0.00025	3.81636	9.84398		0.99005	(5.93)
Female	0	13	0.00027	3.73819	9.28869		0.99005	(5.46)
Female	0	14	0.00031	3.61622	8.70582		0.99005	(5.00)
Female	0	15	0.00034	3.45821	8.09387		0.99005	(4.56)
Female	0	16	0.00036	3.27229	7.45124		0.99005	(4.10)
Female	0	17	0.00039	3.04710	6.77645		0.99005	(3.66)
Female	0	18	0.00041	2.79060	6.06776		0.99005	(3.22)
Female	0	19	0.00044	2.49122	5.32349		0.99005	(2.78)
Female	0	20	0.00046	2.15678	4.54175		0.99005	(2.34)
Female	0	21	0.00047	1.79546	3.72059		0.99005	(1.89)
Female	0	22	0.00049	1.39592	2.85802		0.99005	(1.43)
Female	0	23	0.00050	0.96619	1.95190		0.99005	(0.97)
Female	0	24	0.00051	0.50476	1.00000		0.99005	(0.49)
Female	0	25	0.00053	-	-		0.99005	-
Female	1	0		4.04795	14.45468	10.35006	0.99005	(10.35)
Female	1	1	0.00031	3.94157	14.13180		0.99608	(10.13)
Female	1	2	0.00023	3.90955	13.79156		0.99608	(9.83)
Female	1	3	0.00020	3.90581	13.43383		0.99608	(9.48)
Female	1	4	0.00019	3.91184	13.05800		0.99608	(9.09)
Female	1	5	0.00018	3.92814	12.66318		0.99608	(8.69)
Female	1	6	0.00019	3.93529	12.24866		0.99608	(8.27)
Female	1	7	0.00021	3.92288	11.81358		0.99608	(7.84)
Female	1	8	0.00021	3.90985	11.35664		0.99608	(7.40)
Female	1	9	0.00021	3.89616	10.87676		0.99608	(6.94)
Female	1	10	0.00022	3.87182	10.37288		0.99608	(6.46)
Female	1	11	0.00025	3.81636	9.84398		0.99608	(5.99)
Female	1	12	0.00027	3.73819	9.28869		0.99608	(5.51)
Female	1	13	0.00031	3.61622	8.70582		0.99608	(5.06)
Female	1	14	0.00034	3.45821	8.09387		0.99608	(4.60)
Female	1	15	0.00036	3.27229	7.45124		0.99608	(4.15)
Female	1	16	0.00039	3.04710	6.77645		0.99608	(3.70)
Female	1	17	0.00041	2.79060	6.06776		0.99608	(3.25)
Female	1	18	0.00044	2.49122	5.32349		0.99608	(2.81)
Female	1	19	0.00046	2.15678	4.54175		0.99608	(2.37)
Female	1	20	0.00047	1.79546	3.72059		0.99608	(1.91)
Female	1	21	0.00049	1.39592	2.85802		0.99608	(1.45)
Female	1	22	0.00050	0.96619	1.95190		0.99608	(0.98)
Female	1	23	0.00051	0.50476	1.00000		0.99608	(0.49)
Female	1	24	0.00053	-	-		0.99608	-
Female	2	0		3.94157	14.13180	10.34864	0.99608	(10.35)
Female	2	1	0.00023	3.90955	13.79156		1.01121	(10.04)
Female	2	2	0.00020	3.90581	13.43383		1.01121	(9.68)
Female	2	3	0.00019	3.91184	13.05800		1.01121	(9.29)
Female	2	4	0.00018	3.92814	12.66318		1.01121	(8.88)

Provident Life and Accident Insurance Company
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Sex	Issue Age	Policy Year	Mortality Rate	Net Single Premium	Annuity Factor	CV Exp Allow	Nonforf Premium	Minimum Cash Value
Female	2	5	0.00019	3.93529	12.24866		1.01121	(8.45)
Female	2	6	0.00021	3.92288	11.81358		1.01121	(8.02)
Female	2	7	0.00021	3.90985	11.35664		1.01121	(7.57)
Female	2	8	0.00021	3.89616	10.87676		1.01121	(7.10)
Female	2	9	0.00022	3.87182	10.37288		1.01121	(6.62)
Female	2	10	0.00025	3.81636	9.84398		1.01121	(6.14)
Female	2	11	0.00027	3.73819	9.28869		1.01121	(5.65)
Female	2	12	0.00031	3.61622	8.70582		1.01121	(5.19)
Female	2	13	0.00034	3.45821	8.09387		1.01121	(4.73)
Female	2	14	0.00036	3.27229	7.45124		1.01121	(4.26)
Female	2	15	0.00039	3.04710	6.77645		1.01121	(3.81)
Female	2	16	0.00041	2.79060	6.06776		1.01121	(3.35)
Female	2	17	0.00044	2.49122	5.32349		1.01121	(2.89)
Female	2	18	0.00046	2.15678	4.54175		1.01121	(2.44)
Female	2	19	0.00047	1.79546	3.72059		1.01121	(1.97)
Female	2	20	0.00049	1.39592	2.85802		1.01121	(1.49)
Female	2	21	0.00050	0.96619	1.95190		1.01121	(1.01)
Female	2	22	0.00051	0.50476	1.00000		1.01121	(0.51)
Female	2	23	0.00053	-	-		1.01121	-
Female	3	0		3.90955	13.79156	10.35434	1.01121	(10.35)
Female	3	1	0.00020	3.90581	13.43383		1.03425	(9.99)
Female	3	2	0.00019	3.91184	13.05800		1.03425	(9.59)
Female	3	3	0.00018	3.92814	12.66318		1.03425	(9.17)
Female	3	4	0.00019	3.93529	12.24866		1.03425	(8.73)
Female	3	5	0.00021	3.92288	11.81358		1.03425	(8.30)
Female	3	6	0.00021	3.90985	11.35664		1.03425	(7.84)
Female	3	7	0.00021	3.89616	10.87676		1.03425	(7.35)
Female	3	8	0.00022	3.87182	10.37288		1.03425	(6.86)
Female	3	9	0.00025	3.81636	9.84398		1.03425	(6.36)
Female	3	10	0.00027	3.73819	9.28869		1.03425	(5.87)
Female	3	11	0.00031	3.61622	8.70582		1.03425	(5.39)
Female	3	12	0.00034	3.45821	8.09387		1.03425	(4.91)
Female	3	13	0.00036	3.27229	7.45124		1.03425	(4.43)
Female	3	14	0.00039	3.04710	6.77645		1.03425	(3.96)
Female	3	15	0.00041	2.79060	6.06776		1.03425	(3.48)
Female	3	16	0.00044	2.49122	5.32349		1.03425	(3.01)
Female	3	17	0.00046	2.15678	4.54175		1.03425	(2.54)
Female	3	18	0.00047	1.79546	3.72059		1.03425	(2.05)
Female	3	19	0.00049	1.39592	2.85802		1.03425	(1.56)
Female	3	20	0.00050	0.96619	1.95190		1.03425	(1.05)
Female	3	21	0.00051	0.50476	1.00000		1.03425	(0.53)
Female	3	22	0.00053	-	-		1.03425	-
Female	4	0		3.90581	13.43383	10.36343	1.03425	(10.36)
Female	4	1	0.00019	3.91184	13.05800		1.06219	(9.96)

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Children's Term Rider Form PCTR2.0
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Sex	Issue Age	Policy Year	Mortality Rate	Net Single Premium	Annuity Factor	CV Exp Allow	Nonforf Premium	Minimum Cash Value
Female	4	2	0.00018	3.92814	12.66318		1.06219	(9.52)
Female	4	3	0.00019	3.93529	12.24866		1.06219	(9.08)
Female	4	4	0.00021	3.92288	11.81358		1.06219	(8.63)
Female	4	5	0.00021	3.90985	11.35664		1.06219	(8.15)
Female	4	6	0.00021	3.89616	10.87676		1.06219	(7.66)
Female	4	7	0.00022	3.87182	10.37288		1.06219	(7.15)
Female	4	8	0.00025	3.81636	9.84398		1.06219	(6.64)
Female	4	9	0.00027	3.73819	9.28869		1.06219	(6.13)
Female	4	10	0.00031	3.61622	8.70582		1.06219	(5.63)
Female	4	11	0.00034	3.45821	8.09387		1.06219	(5.14)
Female	4	12	0.00036	3.27229	7.45124		1.06219	(4.64)
Female	4	13	0.00039	3.04710	6.77645		1.06219	(4.15)
Female	4	14	0.00041	2.79060	6.06776		1.06219	(3.65)
Female	4	15	0.00044	2.49122	5.32349		1.06219	(3.16)
Female	4	16	0.00046	2.15678	4.54175		1.06219	(2.67)
Female	4	17	0.00047	1.79546	3.72059		1.06219	(2.16)
Female	4	18	0.00049	1.39592	2.85802		1.06219	(1.64)
Female	4	19	0.00050	0.96619	1.95190		1.06219	(1.11)
Female	4	20	0.00051	0.50476	1.00000		1.06219	(0.56)
Female	4	21	0.00053	-	-		1.06219	-

SERFF Tracking Number: CMPL-126055793 State: Arkansas
 Filing Company: Provident Life and Accident Insurance Company State Tracking Number: 41819
 Company Tracking Number: PLAIC ITL 2-2009
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
 Product Name: PLAIC ITL 2-2009
 Project Name/Number: PLAIC ITL 2-2009/PLAIC ITL 2-2009

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: Provident - Flesch Scores.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: We acknowledge this requirement and are submitting applications with this submission for your review and approval		

	Item Status:	Status Date:
Satisfied - Item: Authorization		
Comments:		
Attachment: PLAIC ITL 2-2009 FORMS authorization.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		
Comments:		
Attachment: Statement of Variability.pdf		

	Item Status:	Status Date:
Satisfied - Item: Certification		
Comments:		

Provident Life and Accident Insurance Company

NAIC #68195-565
FEIN #62-0331200

Form Filing – Individual Term Life Insurance

<u>Flesch Score</u>	<u>Form No.</u>	<u>Description</u>
60	PTL-AR2.0	Level Premium Term Life Insurance Policy
52	PADD2.0	Accidental Death and Dismemberment Benefit Rider
50	PWP2.0	Waiver of Premium for Total Disability Benefit Rider
57	PCTR2.0	Children's Term Rider
54	POIR2.0	Other Insured Term Rider
51	PAE2.0	Amendatory Endorsement
55	PPCE2.0	Policy Change Endorsement
50	PTL App2.0	Individual Term Life Insurance Application
51	PRE App2.0	Re-Entry/Exchange Application
54	PAPPAMD2.0	Amendment of Application
70	PUND QST2.0	Supplemental Underwriting Questionnaire
56	PSOI2.0	Statement of Insurability



J. David Simon, CLU
Compliance Research Services, LLC

Dated: 02-27-2009



1 Fountain Square
Chattanooga, TN 37402
423 294 1011

January 22, 2009

Re: Provident Life and Accident Insurance Company

J. David Simon, CLU
President
Compliance Research Services, LLC
10921 Reed-Hartman Highway, suite 334
Cincinnati, OH 45242

Re: State insurance Department Filings

Dear Mr. Simon:

Provident Life and Accident Insurance Company (Provident) authorizes Compliance Research Services, LLC (CRS) to file on its behalf all administrative forms necessary to administer its closed block of individual life insurance policies. This letter will serve as authorization from Provident for employees of CRS to file policy forms and respond to inquiries on our behalf with all state insurance departments and jurisdictions where Provident is authorized to do business.

Sincerely,

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

By 
[Vice President and Managing Counsel]

STATEMENT OF VARIABILITY

Provident Life and Accident Insurance Company
Level Premium Term Life Insurance Policy Submission
Dated February 23, 2009

Form PTL2.0 / Level Premium Term Life Policy

- **Policy Front Cover**
 1. **Address** - Will insert the Company administrative office address and telephone number.
 2. **Signatures and Titles** - Will insert signature and appropriate title of current Company President and Corporate Secretary.
 3. **Notice of War Risk Exclusion** - Will be included only when policy is issued with a Waiver of Premium Rider and/or an Accidental Death and Dismemberment Rider.
 4. **State of Issue** - Will insert the state where the policy is issued for delivery.
 5. **Insurance Department Information** - Will insert the name and telephone number for the state where the policy is issued for delivery.

- **Policy Data**
 1. **General Contract Information** - All "John Doe" information that may vary from applicant to applicant is bracketed as variable. This includes such information as Policy Number, Issue Date, Insured name, Insured Age, Gender of the Insured, Owner name, Beneficiary name, Plan of Insurance, Conversion Period, Face Amount, Expiry Date, Premium, Frequency of Premium, Schedule of Total Premiums and Premium Class.
 2. **Rider Benefits and Premiums Section** - This information is bracketed to show variability of the riders which the applicant may, or may not elect at the time of application. Also note that the premiums and the benefits payable may vary in accordance to options the applicant elects at the time of application as shown on the Policy Data.
 3. **Table of Annual Policy Premiums** – Will insert the premiums, as appropriate, based upon the policy face amount, age, sex and premium class of the insured at the time of application.
 4. **Address** – Will insert the Company administrative office address and telephone number.

- **Policy Back Cover**
 1. **Address** – Will insert the Company administrative office address and telephone number.
 2. **Notice of War Risk Exclusion** - will be included only when policy is issued with a Waiver of Premium Rider and/or an Accidental Death and Dismemberment Rider.

STATEMENT OF VARIABILITY

Provident Life and Accident Insurance Company
Level Premium Term Life Insurance Policy Submission
Dated February 23, 2009

Forms PAE2.0 / Amendatory Endorsement; PWP2.0 / Waiver of Premium for Total Disability Benefit Rider; PADD2.0 / Accidental Death and Dismemberment Benefit Rider; POIR2.0 / Other Insured Rider; PCTR2.0 / Children's Term Rider;

- **Address and Telephone Number** – Will insert the Company administrative office address and telephone number.
- **Signatures, Titles** – Will insert the signature and appropriate title of current Company President and Corporate Secretary.

Forms SOI2.0 / Statement of Insurability; PUND QST2.0 / Supplemental Underwriting Questionnaire

- **Address and Telephone Number** – Will insert the Company administrative office address and telephone number.

Form PAPPAMD2.0 / Amendment of Application

- **Address and Telephone Number** – Will insert the Company administrative office address and telephone number.
- **Changes Requested** – This form will be used to request changes or to correct information initially provided in application form PREApp2.0.

STATEMENT OF VARIABILITY

Provident Life and Accident Insurance Company
Level Premium Term Life Insurance Policy Submission
Dated February 23, 2009

Forms PREApp2.0 / Re-Entry / Exchange Application; PTLApp2.0 – Individual Term Life Insurance Application

- **Address and Telephone Number** – Will insert the Company administrative office address and telephone number.
- **General Application Information** - All “John Doe” information that may vary from applicant to applicant is intended to be variable.
- **Fair Credit Reporting Act Notice and Authorization For Release of Personal Information (HIPAA Compliant Authorization)** – These notices will be revised based upon revised federal law or regulation regarding such statements.
- **MIB, Inc. Notice (formerly known as the Medical Information Bureau)** – This notice will be revised in accordance with changes required by the MIB, Inc.

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

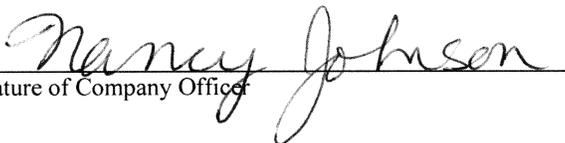
Insurer:

Provident Life and Accident Insurance Company

Form Number(s):

PTL-AR2.0	Level Premium Term Life Insurance Policy
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PAPPAMD2.0	Amendment of Application
PUND QST2.0	Supplemental Underwriting Questionnaire
PSOI2.0	Statement of Insurability

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Nancy Johnson

Name

Vice President, Contract Compliance and Filing

Title

3/20/09

Date

SERFF Tracking Number: CMPL-126055793 State: Arkansas
 Filing Company: Provident Life and Accident Insurance Company State Tracking Number: 41819
 Company Tracking Number: PLAIC ITL 2-2009
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
 Product Name: PLAIC ITL 2-2009
 Project Name/Number: PLAIC ITL 2-2009/PLAIC ITL 2-2009

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/01/2009	Supporting	Flesch Certification Document	03/20/2009	Provident - Flesch Scores.pdf (Superseded)
03/01/2009	Supporting	Certification Document	03/20/2009	AR_AR Certif of Compliance with Rule 19.pdf (Superseded)

Provident Life and Accident Insurance Company

NAIC #68195-565
FEIN #62-0331200

Form Filing – Individual Term Life Insurance

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Provident Life and Accident Insurance Company

By Karen Kinn
Assistant Secretary

Dated: 02-27-2009

Certificate of Compliance with Arkansas Rule and Regulation 19

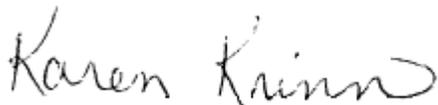
Insurer:

Provident Life and Accident Insurance Company

Form Number(s):

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PAPPAMD2.0	Amendment of Application
PUND QST2.0	Supplemental Underwriting Questionnaire
PSOI2.0	Statement of Insurability

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Karen Krinn
Name

Assistant Secretary
Title

3-12-2009
Date