

SERFF Tracking Number: UNUM-126317287 State: Arkansas  
Filing Company: Provident Life and Accident Insurance Company State Tracking Number: 43594  
Company Tracking Number:  
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
Product Name: Renewable Term Life  
Project Name/Number: Revisions to Term Life Applications/

## Filing at a Glance

Company: Provident Life and Accident Insurance Company  
Product Name: Renewable Term Life SERFF Tr Num: UNUM-126317287 State: Arkansas  
TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- State Tr Num: 43594  
Closed  
Sub-TOI: L04I.103 Renewable - Single Life - Co Tr Num: State Status: Approved-Closed  
Fixed/Indeterminate Premium  
Filing Type: Form Reviewer(s): Linda Bird  
Authors: Julie Mader, Dena Miraldi, Disposition Date: 09/25/2009  
Nancy MacLean  
Date Submitted: 09/24/2009 Disposition Status: Approved-  
Closed  
Implementation Date Requested: On Approval Implementation Date:  
State Filing Description:

## General Information

Project Name: Revisions to Term Life Applications Status of Filing in Domicile: Not Filed  
Project Number: 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: 09/25/2009 Explanation for Other Group Market Type:  
State Status Changed: 09/25/2009  
Deemer Date: Created By: Dena Miraldi  
Submitted By: Julie Mader Corresponding Filing Tracking Number:  
Filing Description:  
Applications L-21721-AR and L-21722-AR are revised to comply with Arkansas Code 23-66-307 and the addition of  
Rule 97, Life Insurance and Annuities Replacement

## Company and Contact

### Filing Contact Information

SERFF Tracking Number: UNUM-126317287 State: Arkansas  
 Filing Company: Provident Life and Accident Insurance Company State Tracking Number: 43594  
 Company Tracking Number:  
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life - Fixed/Indeterminate Premium  
 Product Name: Renewable Term Life  
 Project Name/Number: Revisions to Term Life Applications/

Dena Miraldi, Contract Consultant gmiraldi@unum.com  
 One Fountain Square 423-294-1410 [Phone]  
 Chattanooga, TN 37402

**Filing Company Information**

Provident Life and Accident Insurance CoCode: 68195 State of Domicile: Tennessee  
 Company  
 1 Fountain Square Group Code: 565 Company Type:  
 Chattanooga, TN 37402 Group Name: State ID Number:  
 (800) 451-8475 ext. [Phone] FEIN Number: 62-0331200

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: \$50.00 per submission  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Provident Life and Accident Insurance Company	\$50.00	09/24/2009	30808472

SERFF Tracking Number: UNUM-126317287 State: Arkansas  
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Fixed/Indeterminate Premium  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	09/25/2009	09/25/2009

*SERFF Tracking Number:* UNUM-126317287                      *State:* Arkansas  
*Filing Company:* Provident Life and Accident Insurance Company *State Tracking Number:* 43594  
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*TOI:* L04I Individual Life - Term                      *Sub-TOI:* L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
*Product Name:* Renewable Term Life  
*Project Name/Number:* Revisions to Term Life Applications/

## **Disposition**

Disposition Date: 09/25/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: UNUM-126317287 State: Arkansas  
 Filing Company: Provident Life and Accident Insurance Company State Tracking Number: 43594  
 Company Tracking Number:  
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -  
 Fixed/Indeterminate Premium  
 Product Name: Renewable Term Life  
 Project Name/Number: Revisions to Term Life Applications/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Cover Letter		Yes
Form	Application for Term Voluntary Life Insurance		Yes
Form	Application for Term Voluntary Life Insurance		Yes

SERFF Tracking Number: UNUM-126317287 State: Arkansas  
 Filing Company: Provident Life and Accident Insurance Company State Tracking Number: 43594  
 Company Tracking Number:  
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -  
 Fixed/Indeterminate Premium  
 Product Name: Renewable Term Life  
 Project Name/Number: Revisions to Term Life Applications/

## Form Schedule

Lead Form Number: L-21721-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	L-21721-AR	Application/Enrollment Form	Application for Term Voluntary Life Insurance	Revised	Replaced Form #: L-21721 Previous Filing #:	52.500	L21721-AR.pdf
	L-21722-AR	Application/Enrollment Form	Application for Term Voluntary Life Insurance	Revised	Replaced Form #: L-21722 Previous Filing #:	52.500	L21722-AR.pdf

**PROVIDENT LIFE and ACCIDENT  
INSURANCE COMPANY**

1 Fountain Square  
Chattanooga, TN 37402

**APPLICATION FOR  
TERM VOLUNTARY  
LIFE INSURANCE**

**APPLYING FOR:**

- Employee (Applicant) Coverage  
 Spouse Coverage

Please Print

**Section A: EMPLOYEE (Applicant) Information - Always complete.**

1. Name (First) (Middle) (Last)				2. Social Security No.	
3. Residence Address (Street/Box No.)		(City)		(State) (Zip)	
4. Birthdate	5. Age	6. Sex <input type="checkbox"/> F <input type="checkbox"/> M	7. Home Phone Number		
8. Employer's Name		9. Employment Date	10. Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Employee/Payroll No.	
<b>If applying for Employee (Applicant) Policy, please complete the following:</b>					
12. Have you used any tobacco products (cigarettes, cigars, snuff/dip/chew, pipe) and/or any nicotine delivery systems within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
13. Primary Beneficiary/Relationship			14. Contingent Beneficiary/Relationship		

**Section B: SPOUSE Information (Complete ONLY if applying for Spouse coverage)**

15. Name (First) (Middle) (Last)				16. Coverage Type <input type="checkbox"/> Policy or <input type="checkbox"/> Rider	
17. Birthdate	18. Age	19. Sex <input type="checkbox"/> F <input type="checkbox"/> M	20. Occupation		
21. Has Spouse been hospitalized or unable to perform the normal duties and activities of a person of like age which are in no way curtailed or altered within the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No .....(If "Yes", complete Section D)					
22. Primary Beneficiary/Relationship			23. Contingent Beneficiary/Relationship		

**Section C: POLICY Information - To be completed for Employee (Applicant) and Spouse Policy coverage.**

	Employee (Applicant)	Spouse
24. (a) Do you or your Spouse have any existing individual life insurance or annuity coverage? If "Yes", Give Company Name .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Will coverage applied for replace or modify any existing individual life insurance or annuity coverage? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Face Amount of Coverage (Plan is 10/10 YRT, unless age 61 or older then 10/YRT) .....	\$ _____	\$ _____
26. Base Policy Premium .....	\$ _____	\$ _____
<b>Riders and Premiums:</b>		
<input type="checkbox"/> ADB .....	\$ _____	\$ _____
<input type="checkbox"/> Children's Term (# of Units ____ ) Cannot be on both the employee & spouse policy .....	\$ _____	\$ _____
<input type="checkbox"/> Spouse Term .....	\$ _____	Not Applicable
<input type="checkbox"/> Waiver of Premium .....	\$ _____	Not Applicable
<input type="checkbox"/> Other .....	\$ _____	\$ _____
<input type="checkbox"/> Other .....	\$ _____	\$ _____
Payroll Premium Deducted <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other .....	Total \$ _____	\$ _____
<b>TOTAL PAYROLL PREMIUM: \$ _____</b>		

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

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

**SECTION D: MODIFIED GUARANTEED ISSUE: EMPLOYEE (Applicant) and / or SPOUSE Coverage**  
(Complete as required for all applicants, in addition to previous questions)

	Employee (Applicant)	Spouse
27. Have you ever tested positive for the HIV virus, its antibodies, or been diagnosed with or received treatment for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
28. In the last 12 months, have you:		
(a) Been diagnosed with or treated for cancer, renal failure, insulin dependent Diabetes or chronic Hepatitis? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Been diagnosed with or treated for chronic lung disease, schizophrenia or manic depressive disorder? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Had heart surgery, or been diagnosed or treated for a heart attack or a stroke? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Been convicted for drug and/or alcohol abuse or DUI or DWI? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Had a recurrent disability, been disabled or are you disabled now? .....	Not Applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No

**EMPLOYEE (APPLICANT) STATEMENTS**

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

Insurance will become effective as of my application signed date. Coverage will remain in effect unless Provident determines that the proposed insured(s) is(are) not a risk acceptable under its rules, limits and standards for the plan and amount applied for without modification. In such event, you will be notified.

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

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

\_\_\_\_\_  
(City, State)

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

**Employee (Applicant) Signature**  
\_\_\_\_\_

**Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud.**

**AGENT STATEMENTS:** (1) Do you have any knowledge or reason to believe that the applicant has any existing individual life insurance or annuity coverage?  Yes  No (2) Do you have knowledge or reason to believe that the proposed insurance is intended to replace any existing individual life insurance or annuities?  Yes  No (3) To the best of your knowledge and belief, the above statements and answers are complete and true.

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

**Licensed Agent's Signature**  
\_\_\_\_\_

Agents' License No. \_\_\_\_\_

Printed Name of Agent \_\_\_\_\_

**Policy Number:**  
Employee (Applicant) \_\_\_\_\_  
Spouse \_\_\_\_\_

**PROVIDENT LIFE and ACCIDENT  
INSURANCE COMPANY**

1 Fountain Square  
Chattanooga, TN 37402

**APPLICATION FOR  
TERM VOLUNTARY  
LIFE INSURANCE**

**APPLYING FOR:**

- Employee (Applicant) Coverage  
 Spouse Coverage

Please Print

**Section A: EMPLOYEE (Applicant) Information - Always complete.**

1. Name (First) (Middle) (Last)				2. Social Security No.	
3. Residence Address (Street/Box No.)		(City)		(State) (Zip)	
4. Birthdate	5. Age	6. Sex <input type="checkbox"/> F <input type="checkbox"/> M	7. Home Phone Number		
8. Employer's Name		9. Employment Date	10. Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Employee/Payroll No.	
<b>If applying for Employee (Applicant) Policy, please complete the following:</b>					
12. Have you used any tobacco products (cigarettes, cigars, snuff/dip/chew, pipe) and/or any nicotine delivery systems within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
13. Primary Beneficiary/Relationship			14. Contingent Beneficiary/Relationship		

**Section B: SPOUSE Information (Complete ONLY if applying for Spouse coverage)**

15. Name (First) (Middle) (Last)				16. Coverage Type <input type="checkbox"/> Policy or <input type="checkbox"/> Rider	
17. Birthdate	18. Age	19. Sex <input type="checkbox"/> F <input type="checkbox"/> M	20. Occupation		
21. Has Spouse been hospitalized or unable to perform the normal duties and activities of a person of like age which are in no way curtailed or altered within the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No .....(If "Yes", complete Section D)					
22. Primary Beneficiary/Relationship			23. Contingent Beneficiary/Relationship		

**Section C: POLICY Information - To be completed for Employee (Applicant) and Spouse Policy coverage.**

	Employee (Applicant)	Spouse
24. (a) Do you or your Spouse have any existing individual life insurance or annuity coverage? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If "Yes", Give Company Name</b> .....	_____	_____
(b) Will coverage applied for replace or modify any existing individual life insurance or annuity coverage? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Face Amount of Coverage (Plan is 10/10 YRT, unless age 61 or older then 10/YRT) .....	\$ _____	\$ _____
26. <b>Base Policy Premium</b> .....	\$ _____	\$ _____
<b>Riders and Premiums:</b>		
<input type="checkbox"/> ADB .....	\$ _____	\$ _____
<input type="checkbox"/> Children's Term (# of Units ____ ) Cannot be on both the employee & spouse policy .....	\$ _____	\$ _____
<input type="checkbox"/> Spouse Term .....	\$ _____	Not Applicable
<input type="checkbox"/> Waiver of Premium .....	\$ _____	Not Applicable
<input type="checkbox"/> Other .....	\$ _____	\$ _____
<input type="checkbox"/> Other .....	\$ _____	\$ _____
Payroll Premium Deducted <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other .....	Total \$ _____	\$ _____
<b>TOTAL PAYROLL PREMIUM:</b> \$ _____		

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

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

**SECTION D: MODIFIED GUARANTEED ISSUE: EMPLOYEE (Applicant) and / or SPOUSE Coverage**  
(Complete as required for all applicants, in addition to previous questions)

	Employee (Applicant)	Spouse
27. Have you ever tested positive for the HIV virus, its antibodies, or been diagnosed with or received treatment for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
28. In the last 12 months, have you:		
(a) Been diagnosed with or treated for cancer, renal failure, insulin dependent Diabetes or chronic Hepatitis? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Been diagnosed with or treated for chronic lung disease, schizophrenia or manic depressive disorder? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Had heart surgery, or been diagnosed or treated for a heart attack or a stroke? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Been convicted for drug and/or alcohol abuse or DUI or DWI? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Had a recurrent disability, been disabled or are you disabled now? .....	Not Applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION E: SIMPLIFIED ISSUE LEVEL 1: EMPLOYEE (Applicant) Policy Only**  
(Complete as required in addition to previous questions)

29. Annual Salary \$	30. Height ft. in.	31. Weight lbs.
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32. Have you ever had or been treated for: stroke, congestive heart failure, chronic lung disease (including emphysema), insulin-dependent diabetes, hepatitis (other than type A), cirrhosis of the liver, renal hypertension or failure, systemic lupus or any connective tissue disease? .....  Yes  No

33. In the last 5 years, have you been diagnosed or treated for: psychosis, internal cancer (including melanoma), leukemia or Hodgkin's disease, alcoholism or drug abuse, or had heart surgery, heart attack or transient ischemic attack (TIA)? .....  Yes  No

34. In the last 2 years, have you been put on probation or convicted of a felony, misdemeanor, DUI or DWI? .....  Yes  No

**EMPLOYEE (APPLICANT) STATEMENTS**

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

Insurance will become effective as of my application signed date. Coverage will remain in effect unless Provident determines that the proposed insured(s) is(are) not a risk acceptable under its rules, limits and standards for the plan and amount applied for without modification. In such event, you will be notified.

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

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

\_\_\_\_\_  
(City, State)

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

**Employee (Applicant) Signature**

**Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud.**

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

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

**AGENT STATEMENTS:** (1) Do you have any knowledge or reason to believe that the applicant has any existing individual life insurance or annuity coverage?  Yes  No (2) Do you have knowledge or reason to believe that the proposed insurance is intended to replace any existing individual life insurance or annuities?  Yes  No (3) To the best of your knowledge and belief, the above statements and answers are complete and true.

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

**Licensed Agent's Signature**

Agents' License No. \_\_\_\_\_

Printed Name of Agent \_\_\_\_\_

**Policy Number:**  
Employee (Applicant) \_\_\_\_\_  
Spouse \_\_\_\_\_

SERFF Tracking Number: UNUM-126317287 State: Arkansas  
 Filing Company: Provident Life and Accident Insurance Company State Tracking Number: 43594  
 Company Tracking Number:  
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## Supporting Document Schedules

	Item Status:	Status Date:
<p><b>Satisfied - Item:</b> Flesch Certification  <b>Comments:</b>  <b>Attachments:</b>            AR Regulation 19 Certificate.pdf            AR Readability Cert.pdf</p>		
<p><b>Bypassed - Item:</b> Application  <b>Bypass Reason:</b> not a policy filing  <b>Comments:</b></p>		
<p><b>Satisfied - Item:</b> Cover Letter  <b>Comments:</b>  <b>Attachment:</b>            AR Filing Letter.pdf</p>		

**CERTIFICATION REQUIRED BY  
ARKANSAS INSURANCE DEPARTMENT REGULATION 19**

I certify that this submission meets the provisions of Regulation 19 as well as all other applicable requirements of the Arkansas Insurance Department.

  
Signature

Joanna Shepich  
Director and Assistant Secretary

Date: 09/24/2009

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY  
CHATTANOOGA, TENNESSEE





1 Fountain Square  
Chattanooga, TN 37402  
423 294 1011  
www.unum.com

September 24, 2009

Arkansas Department of Insurance  
Compliance and Health Section  
1200 West Third Street  
Little Rock, AR 72201

**RE: PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY  
NAIC CO. # 565-68195**

L-21721-AR, Application for Term Voluntary Life Insurance  
L-21722-AR, Application for Term Voluntary Life Insurance

Enclosed for your review and consideration for approval are final print copies of the above referenced applications. We have revised these applications to comply with revised Arkansas Code §23-66-307 and the addition of Rule 97, Life Insurance and Annuities Replacement.

We have made the following revisions to applications L-21721 and L-21722:

Revised Question 24 in Section C by adding the following question: “(a) Do you or your Spouse have any existing individual life insurance or annuity coverage?”

Revised AGENT STATEMENTS by adding the following question: “(1) Do you have any knowledge or reason to believe that the applicant has any existing individual life insurance or annuity coverage?”

These revised applications will replace L-21721 and L-21722, filed and approved with Term Voluntary Life Policy L-21715 on April 25, 2000.

If you have any questions regarding this filing, please contact me by telephone at 1-800-451-8475, extension 41410, by fax at 423-294-8346 or by email at [gmiraldi@unum.com](mailto:gmiraldi@unum.com).

Sincerely,

Gaydena (Dena) B. Miraldi, HIA, ACS  
Contract Consultant