Filing at a Glance

Company: Provident Life and Accident Insurance Company

Product Name: ISTD Application	SERFF Tr Num: UNUM-128207798	State: Arkansas
TOI: H11I Individual Health - Disability Income	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H11I.002 Short Term - Unrelated to marketing with employer or association groups	Co Tr Num: L-21774-SP	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Laneeta Derrick, Sandy Kirkman, Julie Mader	Disposition Date: 03/27/2012
	Date Submitted: 03/27/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 03/20/2012
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 03/27/2012
	State Status Changed: 03/27/2012
Deemer Date:	Created By: Sandy Kirkman
Submitted By: Sandy Kirkman	Corresponding Filing Tracking Number:

Filing Description:

This is an informational filing for the Spanish translation of a previously approved English Application for Voluntary Life Insurance. The English version of L-21774-AR-SP, L-21774-AR, was approved July 19, 2004 and is attached under the Supporting Documentation tab along with the Translation Certification.

Please let me know if there is any additional information we can provide to assist in your evaluation of this filing.

Thank you for your review this submission.

Company and Contact

Filing Contact Information

Sandy Kirkman, Senior Contract Consultant
One Fountain Square
Chattanooga, TN 37402
skirkman@unum.com
423-294-8981 [Phone]

Filing Company Information

Provident Life and Accident Insurance Company	CoCode: 68195	State of Domicile: Tennessee
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	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	$50.00 per filing.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Provident Life and Accident Insurance Company	$50.00	03/27/2012	57504729

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/27/2012	03/27/2012

Disposition

Disposition Date: 03/27/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UNUM-128207798*	*State:*	*Arkansas*
Filing Company:	*Provident Life and Accident Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*L-21774-SP*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.002 Short Term - Unrelated to marketing with employer or association groups*
Product Name:	*ISTD Application*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Translation Certification for L-21774-AR-SP	Approved-Closed	Yes
Supporting Document	L-21774-AR ISTD Application	Approved-Closed	Yes
Form	ISTD Application	Approved-Closed	Yes

Form Schedule

Lead Form Number: L-21774-AR-SP

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/27/2012	L-21774-AR-SP	Application/Enrollment Form	ISTD Application	Initial			L-21774-AR-SP.pdf

PROVIDENT LIFE and ACCIDENT INSURANCE COMPANY
1 Fountain Square
Chattanooga, TN 37402

SOLICITUD DE EMISIÓN SIMPLIFICADA DE SEGURO VOLUNTARIO DE INGRESOS POR INCAPACIDAD

☐ Nueva Póliza
☐ Póliza Adicional [Aumento del Beneficio Mensual]
☐ Reemplazo de Póliza Interna
☐ Cambio a Póliza Vigente

Por favor, llene en letra imprenta

Sección A: EMPLEADO (Información del Solicitante)

1. Nombre (Primer Nombre) (Segundo Nombre) (Apellido) (Aquí denominado "Usted")				2. N.º del Seguro Social
3. Dirección del Domicilio (Calle/Apartado de Correos) (Ciudad) (Estado) (Código)				
4. Fecha de Nacimiento	4a. Estado de Nacimiento	5. Edad	6. Sexo ☐ F ☐ M	7. N.º de Teléfono del Domicilio
8. Nombre del Empleador	9. Fecha de Inicio del Empleo	10. ¿Se encuentra laboralmente activo? ☐ Sí ☐ No		11. N.º de Empleado/Nómina de Pago
12. Ocupación		13. Horas trabajadas por Semana		14. Sueldo Mensual $

Sección B: INFORMACIÓN DE LA PÓLIZA

15. Clase de Riesgo: _____
16. Período de Eliminación por Accidentes: _____ días
17. Período de Eliminación por Enfermedades: _____ días
18. Período de Beneficios para Accidentes y Enfermedades: _____ meses
19. Cobertura Seleccionada

	Beneficio Mensual	Prima
Enfermedades y Accidentes Fuera del Trabajo	$ _____	$ _____
☐ Accidentes en el Trabajo	$ _____	$ _____
☐ Otro	$ _____	$ _____

20. Monto Total de las Primas: ..... $ _____
21. Prima deducida del cheque de pago:

☐ Semanal ☐ Bisemanal ☐ Semimensual ☐ Mensual ☐ Otro _____

PRIMA TOTAL DEL CHEQUE DE PAGO: ..... $ _____

22. ¿La cobertura solicitada reemplazará o modificará algún seguro de incapacidad? Si la respuesta es "sí", proporcione los detalles a continuación, y llene y envíe los formularios de sustitución requeridos, si es necesario. ..... ☐ Sí ☐ No

Compañía de Seguros	Beneficio Mensual	Número de Póliza

23. ¿Tiene algún seguro colectivo (sin incluir el pagado por el empleador) o individual de incapacidad actualmente en vigencia con nosotros o con otra compañía que no se reemplazará ni modificará? Si la respuesta es "sí", proporcione detalles a continuación..... ☐ Sí ☐ No

Compañía de Seguros	Beneficio Mensual	Período de Beneficio/Eliminación

Sección C: EMISIÓN MODIFICADA (Llene según se requiera además de las preguntas anteriores).

24. ¿Ha tenido usted un resultado positivo en el análisis del Virus de Inmunodeficiencia Humana (VIH) o sus anticuerpos; o se le ha diagnosticado Síndrome de Inmunodeficiencia Adquirida (SIDA) o Complejo Relacionado con el SIDA (CRS), o ha recibido tratamiento contra estas enfermedades? ..... ☐ Sí ☐ No

25. En los últimos 12 meses, por motivos que no sean un resfrío, una gripe o un embarazo, ¿ha tenido que ausentarse del trabajo o tomarse vacaciones durante 5 días consecutivos o más debido a un accidente, una enfermedad o un problema muscular o de espalda, rodilla, cuello, hombro o articulaciones?..... ☐ Sí ☐ No

26. En los últimos 12 meses, ¿ha recibido asesoramiento médico, solicitado tratamiento, incluyendo medicamentos, o sido hospitalizado por alguno de los siguientes problemas?..... ☐ Sí ☐ No

- Ataque Cardíaco/Cirugía Cardíaca
- Insuficiencia Cardíaca Congestiva
- Accidente Cerebrovascular/Accidente Isquémico Transitorio (AIT)
- Hipertensión Arterial Tratada con 3 o más medicamentos
- Diabetes Insulino-Dependiente
- Cáncer (excepto cáncer de piel basocelular)
- Hepatitis B y C
- Cirrosis

Sección D: EMISIÓN SIMPLIFICADA (Llene según se requiera, además de la Sección C).

27. Estatura _____ pies _____ pulgadas Peso _____ libras

28. En los últimos 5 años, ¿ha recibido asesoramiento médico, solicitado tratamiento, incluyendo medicamentos, por alguno de los siguientes problemas?..... ☐ Sí ☐ No

- Ataque Cardíaco/Cirugía Cardíaca
- Insuficiencia Cardíaca Congestiva
- Accidente Cerebrovascular/Acidente Isquémico Transitorio (AIT)
- Cáncer (excepto cáncer de piel basocelular)
- Insuficiencia renal (riñón) en su etapa terminal
- Enfermedad Pulmonar Obstructiva Crónica/Enfisema
- Enfermedad del higado/Hepatitis B y C/Cirrosis
- Trastorno Neurológico/Esclerosis múltiple
- Síndrome de Fatiga Crónica
- Fibromialgia

29. En los últimos 5 años, ¿ha recibido asesoramiento médico, solicitado tratamiento, incluyendo medicamentos, por alguno de los siguientes problemas? (Si la respuesta es “sí”, proporcione detalles a continuación). ..... ☐ Sí ☐ No

- Lesión o Enfermedad de Espalda
- Lesión o Enfermedad de Rodilla
- Lesión o Enfermedad de Cuello
- Lesión o Enfermedad de Articulaciones
- Lesión o Enfermedad Muscular
- Síndrome del Túnel Carpiano
- Diabetes
- Lectura de Presión Arterial de 140/90 o superior

30. En los últimos 5 años, ¿ha sufrido trastornos médicos que no se hayan divulgado anteriormente durante el proceso de solicitud para incluir pruebas de diagnóstico? Si la respuesta es “sí”, proporcione detalles a continuación. ..... ☐ Sí ☐ No

31. ¿Toma actualmente medicamentos recetados? Si la respuesta es “sí”, proporcione detalles a continuación. ..... ☐ Sí ☐ No

Condición	Medicamentos	Fecha de Inicio	Médico/Hospital	Tipo de Tratamiento	Fecha de Recuperación

Nombre del Empleado: (Solicitante) _____

N.º del Seguro Social del Empleado: (Solicitante) _____

DECLARACIONES DEL EMPLEADO (SOLICITANTE)

Yo comprendo que la cobertura emitida se basa en todas las declaraciones y respuestas arriba registradas. Estas declaraciones y respuestas están completas y son verdaderas. Comprendo que, en mi carácter de persona que firma, a continuación, soy el dueño de la cobertura emitida según esta solicitud.

Yo comprendo que la Fecha de Vigencia de la Cobertura del Seguro, de acuerdo a lo indicado en el Programa de la Póliza se encuentra sujeta a la aceptación de la solicitud de acuerdo a las normas, los límites y los estándares de Provident, y el seguro es, o habría sido emitido según se solicitó (o si no es emitido según se solicitó, entonces según sus enmiendas). La Fecha de Vigencia de la Cobertura será después de la fecha en que se firme la solicitud y antes de la fecha en que comiencen las deducciones del cheque o el cobro de las primas para las pólizas que no se deduzcan del cheque de pago.

Yo he recibido el Preaviso de MIB, Inc. Por medio del presente documento, autorizo a los siguientes que tengan registros o información relacionada con mi persona o mi estado de salud a proporcionar dichos registros o información a Provident o a sus reaseguradores: (a) médico autorizado; (b) profesional médico; (c) hospital, clínica o establecimiento de atención médica; (d) compañía de seguros; (e) empleador; (f) MIB, Inc.; u (g) organización, institución o persona. Esta autorización incluye información relacionada con el consumo de drogas o alcohol o antecedentes, condiciones, consejos o tratamientos relacionados con mi salud física y mental.

También autorizo a todas las fuentes mencionadas (excepto a MIB, Inc.) a proporcionar dichos registros o información a las agencias contratadas por Provident a fin de que los recopilen y transmitan. Una copia fotográfica de esta autorización tendrá la misma validez que la original. Esta autorización es válida por 30 meses a partir de la fecha que se indica a continuación.

Yo autorizo a mi empleador a deducir de mis ingresos las primas de este seguro (a menos que haya completado formularios adicionales para solicitar un método que no afecte el cheque de pago).

Fecha _____ en _____
(Mes/Día/Año) (Ciudad, Estado)

☐ Si esta casilla está marcada, la solicitud ha sido autorizada mediante una inscripción protegida por número de PIN y no se requiere la firma.

Firma del Empleado (Solicitante)

Toda persona que, con el propósito de estafar a una compañía de seguros o, a sabiendas, facilite el fraude a una compañía de seguros, presente una solicitud o una reclamación con declaraciones falsas o engañosas será culpable de fraude en materia de seguros.

DECLARACIONES DEL AGENTE: (1) ¿Tiene conocimiento o alguna razón para creer que el seguro propuesto tiene por objetivo sustituir cualquier seguro o anualidad vigentes? ☐ Sí ☐ No (2) A su leal saber y entender, las anteriores declaraciones y respuestas son completas y verdaderas.

Fecha _____
(Mes/Día/Año)

N.º de Licencia del Agente _____

Nombre del Agente en Letra de Imprenta _____

Firma del Agente Autorizado

Número de Póliza: _____

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	03/27/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	03/27/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	03/27/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	03/27/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Translation Certification for L-21774-AR-SP	Approved-Closed	03/27/2012

Comments:

Attachment:

Certification_for_L-21774-AR-SP.pdf

SERFF Tracking Number:	*UNUM-128207798*	*State:*	*Arkansas*
Filing Company:	*Provident Life and Accident Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*L-21774-SP*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.002 Short Term - Unrelated to marketing with employer or association groups*
Product Name:	*ISTD Application*		
Project Name/Number:	*/*		

		Item Status:	**Status Date:**
Satisfied - Item:	L-21774-AR ISTD Application	Approved-Closed	03/27/2012

Comments:

Attachment:

L-21774-AR.pdf

unum

CERTIFICATION

I, Zary Colón, an employee of Unum Group, do hereby certify the following document as a true and accurate translation from English into Spanish:

Form L-21774-AR-SP

Unum Group affirms that Zary Colón is qualified to translate and review insurance related documents from English to Spanish.

Zary Colón

Dated: 3/26/2012

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

PROVIDENT LIFE and ACCIDENT INSURANCE COMPANY
1 Fountain Square
Chattanooga, TN 37402

SIMPLIFIED ISSUE APPLICATION FOR VOLUNTARY DISABILITY INCOME INSURANCE

☐ New Policy
☐ Additional Policy [Increase Monthly Benefit]
☐ Internal Policy Replacement
☐ Change to Existing Policy

Please Print

Section A: EMPLOYEE (Applicant Information)

1. Name (First) (Middle) (Last) (Herein called You)				2. Social Security No.
3. Residence Address (Street/Box No.) (City) (State) (Zip)				
4. Birthdate	4a. State of Birth	5. Age	6. Sex ☐ F ☐ M	7. Home Phone Number
8. Employer's Name	9. Employment Date	10. Are you actively at work? ☐ Yes ☐ No		11. Employee/Payroll No.
12. Occupation		13. Hours worked per Week		14. Monthly Salary $

Section B: POLICY INFORMATION

15. Risk Class: _____
16. Elimination Period for Accidents: _____ days
17. Elimination Period for Sickness: _____ days
18. Benefit Period for Accidents and Sickness: _____ months
19. Coverage Selected

	Monthly Benefit	Premium
Sickness and Off Job Accidents	$ _____	$ _____
☐ On Job Accidents	$ _____	$ _____
☐ Other	$ _____	$ _____

20. Total Premium Amount: ..... $ _____
21. Payroll Premium Deducted:
☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

TOTAL PAYROLL PREMIUM: ..... $ _____

22. Will coverage applied for replace or modify any disability insurance? If "yes," provide details below and complete and submit required replacement forms if needed. ..... ☐ Yes ☐ No

Insurance Company	Monthly Benefit	Policy Number

23. Do you have any group (excluding employer paid) or individual disability insurance now in force with us or any other company that <u>will not</u> be replaced or modified? If "yes," give details below. ☐ Yes ☐ No

Insurance Company	Monthly Benefit	Elimination/Benefit Period

Section C: MODIFIED ISSUE (Complete as required in addition to previous questions)

24. Have you ever tested positive for the HIV virus or its antibodies, or been diagnosed with or received treatment for acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? ..... ☐ Yes ☐ No

25. In the past 12 months, other than colds, flu or pregnancy, have you taken time off from work or taken vacation for 5 or more consecutive days due to an accident, sickness, back, knee, neck, shoulder, joint or muscular disorder? ..... ☐ Yes ☐ No

26. In the past 12 months have you received medical advice, sought treatment, including medication, or been hospitalized for any of the following: ..... ☐ Yes ☐ No

- Heart Attack/Heart Surgery
- Congestive Heart Failure
- Stroke/Transient Ischemic Attack (TIA)
- High Blood Pressure treated with 3 or more medications
- Insulin Dependent Diabetes
- Cancer (except basal cell skin cancer)
- Hepatitis B&C
- Cirrhosis

Section D: SIMPLIFIED ISSUE (Complete as required, in addition to Section C)

27. Height _____ ft. _____ in. Weight _____ lbs.

28. In the past 5 years have you received medical advice or sought treatment, including medication, for any of the following: ..... ☐ Yes ☐ No

- Heart Attack/Heart Surgery
- Congestive Heart Failure
- Stroke/Transient Ischemic Attack (TIA)
- Cancer (except basal cell skin cancer)
- End Stage Renal/Kidney Disease
- Chronic Obstructive Pulmonary Disease/Emphysema
- Liver Disease/Hepatitis B&C/Cirrhosis
- Neurological Disorder/Multiple Sclerosis
- Chronic Fatigue Syndrome
- Fibromyalgia

29. In the past 5 years have you received medical advice or sought treatment, including medication, for any of the following: (If "yes," give full details below.) ..... ☐ Yes ☐ No

- Back Injury or Illness
- Knee Injury or Illness
- Neck Injury or Illness
- Joint Injury or Illness
- Muscular Injury or Illness
- Carpal Tunnel Syndrome
- Diabetes
- Blood Pressure Reading of 140/90 or above

30. In the past 5 years have you had any medical disorders not previously disclosed during the application process to include diagnostic testing? If "yes," give full details below. ..... ☐ Yes ☐ No

31. Are you currently taking any prescribed medication? If "yes," give full details below. ..... ☐ Yes ☐ No

Condition	Medication	Date of Onset	Doctor/Hospital	Type Treatment	Date of Recovery

Employee Name: (Applicant) _____ Employee SSN: (Applicant) _____

EMPLOYEE (APPLICANT) STATEMENTS

I understand that coverage issued is based on all statements and answers recorded above. These statements and answers are complete and true. I understand that as the undersigned, I am the owner of any coverage issued under this application.

I understand the Coverage Effective Date of insurance as shown in the Policy Schedule is subject to the application being acceptable under Provident's rules, limits and standards and the insurance is, or would have been issued as applied for (or if not issued as applied for, then as modified). The Coverage Effective Date will be no earlier than the application signed date and no later than the date payroll deductions begin or premiums are collected for non-payroll deducted policies.

I have received the MIB, Inc. PreNotice. I hereby authorize any of the following who have any records or knowledge of me or my health to give such to Provident or its reinsurer(s): (a) licensed physician; (b) medical practitioner; (c) hospital, clinic, or medical or medically related facility; (d) insurance company; (e) employer; (f) the MIB, Inc.; or (g) organization, institution or person. This authorization includes any information relating to use of drugs or alcohol or my mental and physical history, condition, advice or treatment.

I also authorize all said sources (except MIB, Inc.) to give such records or knowledge to any agency contracted by Provident to collect and transmit such data. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for 30 months from the date shown below.

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

Dated _____ at _____
(Month/Day/Year) (City, State)

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

Employee (Applicant) Signature

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

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

Dated _____
(Month/Day/Year)

Agent's License No. _____

Printed Name of Agent _____

Licensed Agent's Signature

Policy Number: _____

LEAVE WITH PROPOSED INSURED

DISCLOSURE NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU (MIB) PRE-NOTICE

Information regarding your insurability will be treated as confidential. Provident Life and Accident Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, 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 company, MIB, upon request, will supply such company with the information in its file.

If you would like to request a copy of information MIB may have in your file, please contact MIB at 866-692-6901 (TTY 866-346-3642). Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedure set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. The website address is www.mib.com.

Provident Life and Accident Insurance Company or its reinsurer(s) may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

LEAVE WITH PROPOSED INSURED

STATEMENT CONCERNING AN INVESTIGATIVE CONSUMER REPORT

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared where information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. No inquiry shall be made which is directed toward determining your sexual orientation. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this information.