



UNUM POLICY CHANGE APPLICATION
For Use In Requesting Policy Changes and Reinstatements
 www.unum.com

APPLICATION INSTRUCTIONS FOR BROKER, EMPLOYER AND APPLICANT

Policy Change Application A-32368 can be used for requested changes and reinstatements of existing individual income protection products underwritten by the following companies:

- Provident Life and Accident Insurance Company
- The Paul Revere Life Insurance Company
- Unum Life Insurance Company of America

Based on change being requested, complete all appropriate sections of this application as instructed below. Be sure to always properly sign and date this application wherever requested, including policy owner signature, if applicable. For combination changes complete the most detailed application/form listed below.

To request:	Complete:
• Any administrative changes	Administrative Change Form A-32394
• Reduction in Benefits	Administrative Change Form A-32394
• Increase an Elimination Period or Decrease a Benefit Period	Administrative Change Form A-32394
• Reinstatement	Sections 1-10 of this application
• Addition of any other Supplemental Benefits	Sections 1-9 of this application
• Reconsideration of Medically Modified Offers	Sections 1-9 of this application
• Increase in Monthly Benefit Amount (Indemnity).....	Sections 1-9 of this application
• Exercise an FIO/GPI/FAO	Application A-32388 or Sections 1-4 and 6-9 of this application
• Decrease an Elimination Period or Increase a Benefit Period	New Business Application A-32366
• Update Plus: Renew Update for another term or exercise Additional Increase Amount.....	Sections 1-4 and 6-9 of this application

Income Series Specific Changes

- Change from Income III Choice to Income II Select..... Administrative Change Form A-32394
- Change from Income III Choice or Income II Select to Income I..... Administrative Change Form A-32394
- Change from Income I to Income III..... Sections 1-9 of this application
- Change from Income I to Income II..... Sections 1-9 of this application
- Change from Income II to Income III..... Sections 1-9 of this application
- Exercise the LTD Insurability Option
- Addition of Term Life Rider
- Addition of LCOI Rider

GENERAL GUIDELINES

- Complete all appropriate sections of this application or other required documentation.
- Sign the application in Section 7: Declaration, Agreement and Authorization.
- When applicable, include the page from Your policy change proposal titled "Proposal Premium Summary (Policy Change)" to ensure the proper changes are made to the policy.
- For reinstatements ONLY complete Section 10: Conditional Receipt for Reinstatement and submit all back premiums.
- As a reminder, please note all dates and reasons seen by personal physician in the medical details section.

Submit application and all supporting documentation/requirements to: Unum
 Attn: New Business Direct, P.O. Box 180156
 Chattanooga, TN 37402-1338



**INCOME PROTECTION
APPLICATION - POLICY CHANGE**

This application can be used for Policy Change requests on policies issued by the following companies:

- Provident Life and Accident Insurance Company
- The Paul Revere Life Insurance Company
- Unum Life Insurance Company of America

I, the Insured (herein referred to as "You," "Your," "I," "Me," or "My") hereby request policy changes based on the following representations.

SECTION 1 REQUESTED CHANGE

- Reinstatement(s)
 Exercise LTD Insurability Option
 Reconsideration(s) on Medically Modified Policies
 Exercise FIO/GPI/FAO
 Additional Coverage(s) as outlined on the attached Premium Summary Sheet

Policy #(s): (1) _____ (2) _____ (3) _____

SECTION 2 PERSONAL INFORMATION

1.(a) Name: (Last, First, Middle)		(b) Sex: <input type="checkbox"/> M <input type="checkbox"/> F	(c) Date of Birth: (Mo/Day/Yr)	
(d) Social Security Number:		(e) Employee ID Number:		
(f) Birthplace: (State/Country)		(g) Length of US Residence:	(h) Residence Phone: ()	
(i) Residence Address: Street/Apt No/P.O. Box No.		City	State	Zip
2.(a) Mailing Address: (if different than above): Street/Apt No/P.O. Box No.		City	State	Zip

3. For the period of time commencing **180 days prior to, and including, the date of this application:**

- (a) Have You been continuously at work on a full time basis performing all the duties of Your occupation without limitation due to injury or sickness? Yes No
- (b) Have You been homebound or hospitalized due to injury or sickness?..... Yes No
- Please provide details for 3(a) - 3(b) _____

SECTION 3 OCCUPATION INFORMATION

1.(a) Since You signed Your original application, has Your occupation, duties or employer changed?..... Yes No
If "Yes," complete 1(b) - 1(h) and 2.

(b) Current Occupation(s):		(c) Current Occupational Duties:		
(d) Current Employer:	(e) How long in current occupation ____/____ Yr(s)/Mo(s)	(f) Business Phone: ()		
(g) What was last day of prior employment?	(h) What is average number of hours worked per week? ____ hours			
2. Business Address: Street/Suite No.		City	State	Zip

SECTION 4 FINANCIAL INFORMATION

Enter Your Earned Income from Your occupation(s) as reported for Federal tax purposes (net after business expenses, if any).	Actual Earned Year to Date	Actual Earned Last Year
	\$	\$
1. Net Earned Income:		
2. Are You a(n): <input type="checkbox"/> Non-owner employee <input type="checkbox"/> Owner (If owner, please check appropriate entity below.)		
<input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> C-Corp <input type="checkbox"/> S-Corp Percent of ownership _____%		

SECTION 5 MEDICAL INFORMATION

Provide details in Medical Details Section for any question(s) marked "yes."

Circle all conditions for any "Yes" response.

- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| 1. Have You used tobacco in the past 12 months?
(Tobacco means cigarettes, cigars, snuff/dip/chew, pipe or Nicotine Delivery Systems) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have You been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have You ever: | | |
| (a) Sought, been advised to seek by a medical professional or received counseling or treatment for the use of alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Used narcotics, cocaine, heroin, hallucinogens, barbiturates, marijuana, or other habit forming drugs; sought, or been advised to seek by a medical professional or received counseling or treatment for or ever been arrested for the possession of or use of prescribed or non-prescribed drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Other than above, have You, within the past 10 years, had medical or surgical advice or treatment, had a physical examination or been under observation by a medical professional for any disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are You presently under observation or treatment by a medical professional or do You have a physical impairment or deformity or take any type of medication?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6a. Do You need human assistance of any kind to perform every day activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example from the chair to Your bed) or have any memory loss or confusion?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6b. Have You ever been diagnosed or treated for or sought diagnosis or treatment for memory loss or confusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do You use any special medical equipment or appliances such as a cane, wheelchair, catheter, oxygen tank, pacemaker or artificial limb?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. (a) What is Your: Height: _____ (feet) _____ (inches) (b) Weight: _____ (pounds) | | |
| 9. Have You, within the past two years, engaged in private aviation, motorcycle riding, motor vehicle or motorboat racing, scuba diving, martial arts, parachuting, gliding or mountain or rock climbing? | <input type="checkbox"/> | <input type="checkbox"/> |

Please provide the Name(s) and Address(s) of Your personal physician(s) or health care facility(ies). If none, write "None." Include date(s) and reason(s) seen by a physician and results in the Medical Details section below. If more than one physician list in Medical Details section.

Personal physician's Name: _____ Address: _____

MEDICAL DETAILS

Please provide any and all symptoms and/or diagnosis, the date of each occurrence, any treatment/medication, any time lost from work and name and address of medical facility and/or physician for each condition to which You circled and answered "Yes" to the questions in Section 5. If more space is needed, please put additional details on a separate piece of paper.

Question #

SECTION 6 EXISTING AND/OR PENDING INSURANCE INFORMATION

1. Is the insurance applied for intended to replace any accident and sickness and/or life insurance including annuities presently in force? Please provide details below..... Yes No
2. Do You have, are You applying for, are You currently eligible for or will You become eligible within the next 12 months for other:
(A) Individual (C) Association (D) LTD (E) Employer Sick Pay Disability Income Coverage (F) Overhead Expense (G) Buy-out (K) Key Person? (If Yes, give details below, including premium payer for coverage being applied for) Yes No
3. (a) Will any premium for coverage being applied for be paid by employer? If yes, what percentage _____ %..... Yes No
(b) Will employer's contribution be included in your taxable income?..... Yes No

Name of Insurance Company(s) or Source(s) (including Provident/ Unum/Paul Revere) Include Policy #	Type of Coverage (Use letter code above)	Monthly Amount/Face Amount		Elimination Period	Benefit Period	Indicate whether this coverage will be changed or replaced* (describe the change)	Effective date of discontinuance	Paid by employer and not in your taxable income?	
		Base	SIS					YES	NO
								<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>

*Please complete and submit state required replacement forms if needed.

Additional Details:

**SECTION 7
DECLARATION, AGREEMENT AND AUTHORIZATION**

It is understood and agreed as follows:

1. I have read the statements and answers recorded above. They are true and complete and correctly recorded. They will become part of this Application and any policy(ies) issued on it, if required.
2. I will permanently discontinue any group or individual policy(ies) shown to be discontinued in answer to question 2 in Section 6 on or before the date(s) indicated. The Company will rely on such answers in determining the amount of, if any, insurance it will issue. Benefits under any policy issued on this application may be reduced by the amount payable under such existing policies.
3. No broker has authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.
4. Benefits under any coverage change will not become payable until I have paid the first full premium for the policy change. If I did not prepay premium with this application, I will be covered under any policy change approved by Unum pursuant to this application only if the Change Statement is delivered to Me and at time of delivery; a) I have accepted all modifications to this application which Unum requires; b) the policy being changed is neither in its grace period nor has terminated, and; c) the statements in this application and in any other supplemental application, medical exam or tests and other questionnaires are then still true and complete.
5. I have received a copy of the Notice of Information Practices (including Medical Information Bureau Notice and Fair Credit Reporting Act Notice).
6. If coverage applied for qualifies as a benefit under an Employee Welfare Benefit Plan established or maintained by the employer and governed by the Employee Retirement Income Security Act (ERISA), the Company and its affiliates will be the claims administrator and have full, final, binding, and exclusive discretion to determine benefits. Pursuant to ERISA the policyholder will be entitled to appeal any claims decision.
7. I UNDERSTAND that if My answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind policy changes made.
8. I HAVE BEEN INFORMED that any person who knowingly and, with intent to injure, defraud or deceive any insurer, submits an application or files a claim containing a false, incomplete or misleading information is guilty of a felony of the third degree.

Signed at: City and State

Dated

I certify that I have truly and accurately recorded on this Application the information that was supplied by the Insured.

Signature of Insured

Witness: Licensed Broker

Signature of Policy Owner

Licensed Broker (Printed or Typed)

Broker License Identification Number

Disclosure Authorization

I AUTHORIZE: any doctor, hospital, clinic, provider of health care, insurance (or reinsuring) company, consumer reporting agency, Medical Information Bureau Inc., My insurance agents, employers or any other person or firm having: (i) Information as to cause, treatment, diagnosis, prognosis or advice of my physical or mental condition; or (ii) any other information needed to determine My eligibility for insurance; to give Provident Life and Accident Insurance Company, Unum Life Insurance Company of America or The Paul Revere Life Insurance Company and its affiliates and its employees and agents, My broker, or any consumer reporting agency, all such information. This may include (but is not limited to); information about driving records, mental illness, and use of alcohol or drugs.

I UNDERSTAND the information obtained with this authorization will be used by the Company to determine My eligibility for insurance. A photocopy of the authorization is valid. I or My authorized representative may request a copy of this authorization. This authorization will be in force for two years and six months from the date shown below.

Signature of Insured

Date

THIS DECLARATION, AGREEMENT AND AUTHORIZATION MUST BE PROPERLY SIGNED, INCLUDING PROPOSED INSURED'S SIGNATURE, BEFORE APPLICATION CAN BE PROCESSED

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

SECTION 8 PRODUCER INFORMATION

(Please type or print the Names, Codes and Shares for all Producers)

Broker's Name*:	Broker's SSN:	Tax I.D. for Credit:	Name of Entity/Company Affiliation:	Production Share (Must total 100%)
1. <input type="checkbox"/>				%
2. <input type="checkbox"/>				%
3. <input type="checkbox"/>				%
4. <input type="checkbox"/>				%

*Check box if you are the writing broker Writing Broker's Phone: _____ Fax and/or Email: _____
 Do you have knowledge or reason to believe that the proposed insurance is intended to replace any existing insurance or annuities? Yes No
 How long have you known the applicant? _____ Was application taken in person? Yes No

Personal History Interview Information: Most convenient time and place for PHI

Phone Number if other than in Section 2 Personal Information: ()

Home Time _____ (Eastern Standard Time) AM PM

Work Time _____ (Eastern Standard Time) AM PM

Please remember to advise Proposed Insured that he/she may be contacted for interview.

REMARKS: _____

SECTION 9 PREMIUM INFORMATION

Policy #(s) that are to be changed:

(1) _____ (2) _____ (3) _____

Select new desired payment method and frequency below.

Payment Method	Frequency:			
	Annual	Semi-Annual	Quarterly	Monthly
<input type="checkbox"/> Individual Direct Bill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (See 1 below)
<input type="checkbox"/> Multi-Life Direct Bill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (See 1 below)
<input type="checkbox"/> Multi-Life List Bill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (See 2 below)

*If Your policy is part of a Multi-Life list bill account, billed premiums and refunds will be sent to the company. If You are not part of a Multi-Life list bill account, all bills, refunds, and correspondence must be mailed to Your attention to the address You specify below.

Insured Residence Address Insured Business Address (Complete below) Other Address (Complete below)
 Check here if You are the policy owner but not the insured and want to specify who should receive bills, refunds and correspondence. Note Name _____ Phone _____
 Address _____
 City _____ State _____ Zip Code _____
 address in the space to the right and check recipient. Recipient: Policy Owner Insured Other

1. INSUREmatic is the only option available for the Monthly Individual or Monthly Multi-Life Direct Bill payment methods. Please complete the Authorization To Transfer Funds Form, L-5562 (9-00) to change an INSUREmatic bank account or to request this billing method.

2. For Monthly Payroll Deduct Multi-Life List Bill accounts, please indicate Your payroll frequency and payroll cycle date:
 (a) Payroll Frequency: Monthly Semi-Monthly Bi-Weekly Weekly (b) Payroll Cycle Date: _____

3. Multi-Life Case Number: _____ Multi-Life Case Name: _____

**SECTION 10
CONDITIONAL RECEIPT FOR REINSTATEMENT**

Received \$ _____ From _____ Date _____

Thank you for prepaying Your full premium along with Your Application for Reinstatement.

Premium payment alone does not mean Your policy is reinstated or that You have any coverage in force. However, in exchange for Your full prepayment, we (Unum and its affiliates) agree to determine whether You are eligible for reinstatement, in accordance with our standard underwriting practices, as of the latest of today's date or the date of any supplemental application, examination or test we require.

If You are eligible for reinstatement, we will offer to reinstate Your policy with any changes in coverage, benefits, exclusions, premium or plan design which, in our discretion, are appropriate based on our underwriting practices. If You accept the coverage we offer to reinstate, Your coverage will be effective on the same date we approve the Application for Reinstatement, except that in no event will You have coverage for any injury that occurred after the policy terminated and before the reinstatement date, or from sickness that begins less than 10 days after the date of reinstatement, or from any disease or condition that is excluded by name or description on the date disability begins.

If we decline your application, or You withdraw it, or You do not accept the terms of the policy we reinstate, we will return any unearned premium to the payor.

This agreement applies to each policy You have prepaid with Your application. If full prepayment does not accompany this Application of Reinstatement, reinstatement of Your policy cannot be effective before full payment is received in the Home Office. This is our entire agreement and may not be altered in any way by anyone.

Licensed Broker (acknowledging receipt of prepayment)

SECTION 11 NOTICE OF INFORMATION PRACTICES

This Notice must be given to Proposed Insured
(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

In considering Your application, information from various sources will be considered. These include Your statements, the results of Your physical examination (if required), and reports we get from doctors or medical facilities which have attended to You.

MEDICAL INFORMATION BUREAU, INC. (MIB)

Pre-Notice: Information regarding Your insurability will be treated as confidential. We, or our reinsurers, may, however, make a brief report thereon to 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 a 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 procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

We, or our reinsurers, 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.

COMPLIANCE NOTICE

We appreciate Your application for insurance coverage. We wish to inform You that an investigative consumer report may be ordered as to Your insurability. This report may include, if applicable, information as to Your character, general reputation, personal characteristics, and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. You may also request to be interviewed in connection with its preparation. If You would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon Your written request to the address below. You may also receive a copy of such report by making written request to us, Your agent or the reporting agency after proper identification.

PRIVACY NOTICE

Personal information may be collected from persons other than You. Such information, as well as other personal or privileged information subsequently collected by us or Your broker may in certain circumstances be disclosed to third parties without authorization and to affiliates of the company only as permitted by law. You have a right of access and correction with respect to all personal information collected. A detailed notice of information practices will be furnished to You upon request.

If You need any assistance, please feel free to contact Your broker or write to:
Unum, Attn: Underwriting, 1 Fountain Square, Chattanooga, TN 37402-1338.