

Applicant Section
 Applicant's Name (First, MI, Last) Employee Spouse Gender M F Birthdate (mm/dd/yyyy) Social Security No.
 Home Address - Street City State Zip Code State of Birth Employee ID/Payroll No.
 Date Employed Occupation/ Job Title Hrs. Worked/ Week Annual Base Salary Home Phone No. Business Phone No.
Billing Section
 Payroll Deduction Employer Name Employer Address (Street-City-State-Zip) Section/Dept. No. Employee Class
 Payer or Owner if other than Applicant (Name, Address, Social Security No.) Payer Owner Both

Spouse and Dependent Section
 Name of Spouse (First, MI, Last) Gender M F Birthdate (mm/dd/yyyy) Relationship Social Security No.
 Employer's Name for Spouse Date Employed Occupation / Job Title Annual Base Salary
 1. Are there any eligible dependent children applying for coverage? Yes No Number Deps: _____

Complete Question 2 for all Products
 2.A. Are you actively working? Applicant Yes No Spouse Yes No
 2.B. If "No", is your spouse disabled or unable to work? Yes No

Plan Section
 Indicate Type of Change (N) New (T) Transfer or (R) Rider Addition. Indicate Tax Status (P) for pre-tax or (A) for after tax

Product	Type of Change	Policy Plan Change	Units/ Amount	Rider Plan/ Units	Rider Plan Code	Rider Plan Code	Tax Status	Monthly Premium
<input type="checkbox"/> Accident							P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Hospital Confinement							P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Cancer							P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Int. Care							P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Critical Illness							P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Disability		Elim/Benefit period					P <input type="checkbox"/> A <input type="checkbox"/>	
Total Monthly Premium \$								

Replacement Section - Complete for all Products
 3. Will any health insurance, with this or any other company, be modified or discontinued if the coverage applied for is issued? if yes, provide details.
 Insured's Name Insurance Company Type of Coverage Policy Number

AIDS Section - Complete for all Products
 4. Have you been diagnosed or received treatment from a physician for HIV, acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)?
 Applicant Yes No Spouse Yes No Dependent Yes No

Simplified Issue Section - Disability and Hospital Confinement
 5. Have you previously purchased disability coverage that will remain in force which, when combined with the coverage you are applying for, will exceed 70% of your gross annual income? This does not include employer paid group disability coverage.
 6. Within the past 12 months, other than colds, flu or normal pregnancy, have you been off work (vacation or sick leave) for 10 or more consecutive work days due to an illness or injury, including back, neck, knee, joint or muscle?
 7. Within the past 12 months, have you received medical advice or sought treatment (including medication) for:
 Heart Attack (MI) Blood Pressure Reading of 160/100 or Above Hepatitis B, C
 Heart Surgery Kidney Disease except Stones Cirrhosis
 Congestive Heart Failure Insulin Dependent Diabetes Hodgkin's Disease
 Stroke Diabetes Diagnosed Prior to age 40 Leukemia
 Transient Ischemic Attack Cancer Other than Skin Cancer

Dependent Health Section - Hospital Confinement
 8. Within the past 12 months, has any dependent been hospitalized for respiratory disorders, including asthma, cystic fibrosis, diabetes, heart condition, cancer (other than skin cancer) or seizures? if yes, provide details.
Any dependent listed will not be covered under the Hospital Confinement policy to which a copy of the application is attached.
 Name (First, MI, Last) Relationship Birthdate (mm/dd/yyyy) Social Security No.

DETACH AND LEAVE WITH APPLICANT

Notice of Insurance Information Practices

We collect Non Public Information (NPI) about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) will affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Our affiliated companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs. This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

If you believe NPI we have about you is incorrect, please write us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

If we decide not issued coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

To receive our complete privacy notice, including more information about our information-sharing, access and correction practices, write to our parent company: Privacy Officer, UnumProvident Corporation, 2211 Congress Street, M347, Portland, Maine 04122. For additional information about our commitment to privacy, visit www.coloniallife.com.
NIP

DETACH AND LEAVE WITH APPLICANT.

DISCLOSURE NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU.

Information regarding your insurability will be treated as confidential. Colonial or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Sussex Station, Boston, Massachusetts 02112, telephone (617) 426-3660.

Colonial or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

MIB