

GROUP LONG TERM DISABILITY INSURANCE WITH EVIDENCE OF INSURABILITY

For Existing Employees of the **STATE UNIVERSITIES OF FLORIDA**

Underwritten by:
UNUM Life Insurance Company of America

Here's how to apply:

1. Complete the application
2. Complete the medical questionnaire
3. Send the completed forms to The Gabor Agency

We'll process your application right away and notify you in 4-6 weeks if you've been approved!

Enrollment and Premium Administration:



The Gabor Agency, Inc.
3500 Financial Plaza, Suite 400
Tallahassee, Florida 32312

Phone: (850) 894-9611 Toll-Free: (800) 330-6115 Fax: (850) 894-4268

www.gaboragency.com

The Gabor Agency, Inc. in partnership with UNUM, is pleased to offer Group Long Term Disability Insurance for eligible employees of the State University System of Florida. This is a unique benefit that offers you a way to "insure your paycheck" in the event of a disability.

Losing your ability to work can be an emotionally and financially devastating event for you and for your family. This program will replace 2/3 of your university income, tax-free, in the event that you are unable to work due to injury or illness.

"Disability" or "Disabled" means that you are limited from performing the material and substantial duties of your occupation and you have a 20% or more loss in earnings because of an injury or sickness. After 24 months of payments, you are disabled when UNUM determines that, due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience. You must be under the regular care of a physician in order to be considered disabled.

The premium for the 90-day elimination period option is \$.61 per \$100 of covered monthly salary; for an additional \$.33 per \$100 of covered monthly salary, you can begin receiving benefits a full 60 days earlier in the event of a disability. Sample deductions are enclosed for your review. The maximum monthly benefit is \$12,000. Your coverage will become effective the first of the month following the date of approval by UNUM. Deductions from your pay will begin in the month in which it takes effect.

ADDITIONAL FEATURES

Retirement Income Benefit

Work Incentive Benefit

3-month Survivor Benefit

Rehabilitation & Return to Work Assistance

Cost of Living Adjustment Benefit

Dependent Care Expense

Worldwide Emergency Travel Assistance

Consider this . . . 3 out of every 10 workers between the ages of 25 and 65 will experience an accident or illness that keeps them out of work for three months or longer.* This program is an inexpensive way to protect your income, yourself and your family. We encourage you to take advantage of this important protection.

*1985 Commissioner's Individual Disability Table, Society of Actuaries.

To take advantage of this opportunity:

- **Complete and sign the attached forms. Your height and weight must be included. Please leave Group and Division numbers blank. NOTE: If your spouse is not an employee of the University system, they are not eligible for this coverage.**

- **Return the forms by mail to:**

The Gabor Agency, Inc.

Attn: Cindy Ragsdale

3500 Financial Plaza, Suite 400

Tallahassee, Florida 32312

UNUM will process your application, and will approve or deny coverage within 4-6 weeks of receipt. Gabor will notify your employer to begin premium deductions when you are approved for coverage.

For full plan details, contact your HR office for a booklet, or visit our website at www.gaboragency.com.

[] NEW APPLICANT

GROUP INSURANCE ENROLLMENT FORM
UNUM Life Insurance Company of
America

[] CHANGE IN COVERAGE

STATE UNIVERSITIES OF FLORIDA
Enrollment for Group Voluntary Disability Coverage

Social Security No.	Employee ID No	Date of Birth	Date of Hire	University
Last Name, First, MI		Job Title		
Street Address				
City	State	Zip Code	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Department/Building and Room Number/Mail Code			Annual Salary: \$ _____	

I am employed on a [9] [10] or [12] month contract (please circle one). I work [] hours per week.

The disability plan has a pre-existing condition limitation. If I have received medical treatment or consultation or taken prescribed drugs or medicines for any sickness or injury within three months prior to my effective date of coverage, these conditions will not be covered unless the disability begins more than twelve (12) consecutive months after my effective date of coverage. My effective date of coverage will be the first day of the month following the date of this application or approval by UNUM, if applicable, provided that I am actively at work on a full time basis.

I understand that if I do not apply for coverage during my initial eligibility period and choose to enroll at a later date, UNUM may require Evidence of Insurability.

I hereby request coverage under my employer's plan of benefits. I authorize my employer to deduct from my earnings my contributions for the coverage when I become eligible and for each period thereafter, automatically including future rate increases, and to calculate into deduction modes consistent with the payroll system of my employer, including prorated and accelerated deductions, as applicable. The deductions are to be continued until:

(a) I request that this authorization be cancelled; or

(b) termination of my employment.

The amounts deducted are to be paid to The Gabor Agency, Inc., Tallahassee, Florida, then remitted to UNUM Life Insurance Company of America to cover premiums for disability coverage provided for me. UNUM Life Insurance Company of America is solely responsible for paying benefits under the policy.

PLEASE SELECT ONE: 30-Day Elimination Period **-or-** 90-Day Elimination Period

Enrollment Date: _____	Effective Date: _____	_____ Signature
		_____ Agent Signature

❖ PREMIUM EXAMPLES ❖

The monthly cost to participate in the 30 day Elimination Period Option is **\$.94 per \$100** of covered monthly salary. Should you prefer to participate in the 90 day Elimination Period Option, the monthly cost is **\$.61 per \$100** of covered monthly salary, collected on a bi-weekly basis.

To help you calculate your monthly premium cost, please refer to the examples below:

If you participate in the:

30 day Elimination Period Option:

$$\begin{array}{r} \$20,000 \\ \text{(Annual salary)} \end{array} \div \begin{array}{r} 12 \\ \text{(months)} \end{array} \div 100 \times \begin{array}{r} \$.94 \\ \text{(per \$100 salary rate-based)} \end{array} = \textbf{\$15.67 Monthly Premium}$$

$$\begin{array}{r} \$40,000 \\ \text{(Annual salary)} \end{array} \div \begin{array}{r} 12 \\ \text{(months)} \end{array} \div 100 \times \begin{array}{r} \$.94 \\ \text{(per \$100 salary rate-based)} \end{array} = \textbf{\$31.33 Monthly Premium}$$

$$\begin{array}{r} \$60,000 \\ \text{(Annual salary)} \end{array} \div \begin{array}{r} 12 \\ \text{(months)} \end{array} \div 100 \times \begin{array}{r} \$.94 \\ \text{(per \$100 salary rate-based)} \end{array} = \textbf{\$47.00 Monthly Premium}$$

Benefits are paid on a **WEEKLY** basis once you have been disabled for 30 days.

90 day Elimination Period Option:

$$\begin{array}{r} \$20,000 \\ \text{(Annual salary)} \end{array} \div \begin{array}{r} 12 \\ \text{(months)} \end{array} \div 100 \times \begin{array}{r} \$.61 \\ \text{(per \$100 salary rate-based)} \end{array} = \textbf{\$10.17 Monthly Premium}$$

$$\begin{array}{r} \$40,000 \\ \text{(Annual salary)} \end{array} \div \begin{array}{r} 12 \\ \text{(months)} \end{array} \div 100 \times \begin{array}{r} \$.61 \\ \text{(per \$100 salary rate-based)} \end{array} = \textbf{\$20.33 Monthly Premium}$$

$$\begin{array}{r} \$60,000 \\ \text{(Annual salary)} \end{array} \div \begin{array}{r} 12 \\ \text{(months)} \end{array} \div 100 \times \begin{array}{r} \$.61 \\ \text{(per \$100 salary rate-based)} \end{array} = \textbf{\$30.50 Monthly Premium}$$

Benefits are paid on a **MONTHLY** basis once you have been disabled for 90 days.

This brochure is a brief summary of the Disability Plan. The complete terms of the coverage are set forth in the Group Policy issued by Unum Life Insurance Company of America. If the Group Policy and this summary differ, the Group Policy will govern.



**PRE-UNDERWRITING OF LATE APPLICANTS
AND THOSE REQUIRING
EVIDENCE OF INSURABILITY
INSTRUCTIONS AND INFORMATION FOR
COMPLETING THE EVIDENCE OF
INSURABILITY FORM**

Unum Life Insurance Company of America

To expedite processing, this form has been designed to be scanned and optically read. Please print neatly and respond to all questions.

1. Fully complete this form when your plan requires you to be individually underwritten to qualify for insurance. Specify what coverage you are requesting. If you are unsure, check with your plan administrator.
2. Make sure you have answered all the questions completely and accurately. Information pertaining to your Employer name, address and Group number, as well as your personal information must be provided. If there are unanswered questions, the underwriting process will not begin.
3. All employees and spouses applying for any coverage requiring underwriting must answer all health questions through section 2. If you are applying for disability coverage, or your life amount requiring underwriting is greater than \$150,000, you must also fill out section 3.
4. Please include your work and home phone number; we may need to request additional information by telephone.
5. Please sign and date where indicated and make a copy of this form for your records. Please send the completed form to your plan administrator or mail the form directly to:

UnumProvident
P.O. Box 9783-5083
Portland, ME 04104

In order to evaluate your application we are relying on the information you have provided. In addition, we may need to request supplemental information from you or your physicians. Some coverage and amounts may require a brief medical exam, a blood test, urinalysis and/or EKG. These tests will be performed at your convenience and can be completed at your place of employment or home. We will notify you if any additional information is needed. UnumProvident will pay for any additional information or tests needed to evaluate your application.

Please answer the following questions to the best of your knowledge and belief:

<p>Has any person applying for coverage 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?</p>	<p align="center"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
<p>Section 1 Dependent Children Health Questions</p>							
<p>1. Within the past 5 years, have any dependent(s) been treated for diabetes, heart disorder, or cancer (other than basal or squamous cell carcinoma of the skin)? Do any dependent(s) have cerebral palsy, cystic fibrosis or muscular dystrophy? If yes, please provide name(s) of children.</p>	<p align="center"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
<p>2. Within the past 2 years, has any dependent been diagnosed or treated for breast cancer?</p>	<p align="center"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
<p>Section 2 Employee and Spouse Health Questions</p>							
<p>All employees and spouses applying for coverage must complete this section.</p>							
<p>1. Within the past 2 years, have you used any controlled substances with the exception of those prescribed by a physician, received medical advice or sought treatment for drug or alcohol abuse, or pled guilty, pled no contest to or been convicted of a felony, misdemeanor, or a charge of operating a motor vehicle under the influence of drugs and/or alcohol?</p>	<table border="1"> <tr> <th align="center">Employee</th> <th align="center">Spouse</th> </tr> <tr> <td align="center">Yes No</td> <td align="center">Yes No</td> </tr> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	Employee	Spouse	Yes No	Yes No	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Employee	Spouse						
Yes No	Yes No						
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>2. Within the past 2 years, have you been prescribed three or more medications to be taken concurrently for high blood pressure?</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>3. Within the past 5 years, have you received medical advice or sought treatment for psychosis, ALS, muscular dystrophy, angina, or internal cancer (other than breast cancer but including melanoma, leukemia or Hodgkin's disease) or had heart surgery, heart attack or transient ischemic attack (TIA)?</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>4. Within the past 2 years, have you been diagnosed with or treated for breast cancer?</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>5. Within the past 10 years, have you received medical advice or sought treatment for stroke, congestive heart failure, chronic lung disease including emphysema, diabetes treated with insulin or oral medications, hepatitis (other than type A), cirrhosis of the liver, chronic renal disease including hypertension or failure, systemic lupus or any connective tissue disease?</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>6. Are you confined to a wheelchair for reasons other than paraplegia?</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>Section 3 If your amount requiring underwriting is greater than \$150,000 or you are applying for disability coverage, you must complete section 3. Otherwise, please sign and return application.</p>							
<p>If you answer yes, please provide details requested in the box on the following page.</p>							
<p>1. Within the past 2 years, have you flown as a student or private pilot, engaged in auto or boat racing, scuba diving, hang gliding, ballooning, flying ultralights, parachuting, mountain climbing or any hazardous sport or avocation that requires special certification or license to participate?</p>	<table border="1"> <tr> <th align="center">Employee</th> <th align="center">Spouse</th> </tr> <tr> <td align="center">Yes No</td> <td align="center">Yes No</td> </tr> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	Employee	Spouse	Yes No	Yes No	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Employee	Spouse						
Yes No	Yes No						
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>2. Have you ever used barbiturates, amphetamines, cocaine, hallucinogenic drugs or any narcotics except as prescribed by a physician or been advised to reduce your consumption of alcohol or been treated, arrested in connection with alcohol, or been told to have counseling for the use of alcohol or drugs? If yes, provide the frequency of use and date last used, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number, date of occurrence and driver's license number and issuing state of any arrest.</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>3. Have you ever pled guilty to, pled no contest to or been convicted of a felony or misdemeanor? If yes, list person's name, reason for arrest(s) and/or are you currently on probation.</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>4. Within the past 2 years, have you pled guilty to, pled no contest to, or been convicted of 3 or more speeding or other moving violations? If yes, list person's name, type of violation(s) and date(s), driver's license number and state of issue.</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>5. Within the past 10 years, have you received medical advice or sought treatment for epilepsy, nervous, emotional or mental disorder, paralysis, skin, bone, muscle, back, knee, neck or joint disorder, muscular or neurological disorders, Fibromyalgia, or Chronic Fatigue Syndrome. If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number.</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>6. Within the past 7 years, have you received medical advice or sought treatment for diabetes, asthma, lung or respiratory disorder, thyroid or other endocrine disease, heart or circulatory disorder, stroke (including TIA), chest pain, high blood pressure, cancer, gastro-intestinal, genitourinary, kidney or liver disease? If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number.</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>7. Within the past 7 years, have you consistently taken any over the counter medications, natural supplements other than vitamins, or received any therapeutic treatments? If yes, list all over the counter medications including any natural supplements, dosage, condition and date of onset. Please also list therapies and associated conditions and dates treatment received.</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>8. Within the past 7 years, have any medications been prescribed or have you consulted a medical professional for anything other than the conditions above, or are you contemplating any operation or visit to a physician for an injury or ailment? If yes, provide details, dates of occurrence, medications, treatment and medical professional's name, address and phone number.</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
<p>9. Do you have any condition that prevents or limits activities or are you now pregnant? If yes, provide details and describe the limitation(s). If pregnant, please provide expected delivery date.</p>	<table border="1"> <tr> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						

Details for any "yes" answers

Question Number	Name	Detailed Description	Date	Duration	Treatment Received and Recovery	Names and Addresses of Physicians and Hospitals

Please attach additional sheet if you need additional space

Authorization

I authorize any person or organization to give UnumProvident Corporation subsidiaries or their duly authorized representatives (UnumProvident) any of the following:

- information about any injury or illness I have or I have had, including AIDS, mental illness or drug or alcohol abuse. This authorization excludes disclosure of HIV test results. Such test results shall not be disclosed or published. I understand that nothing in this caveat will prohibit this authorization from including the fact that an applicant has AIDS.
- information about my medical history including any consultations, prescriptions, treatments or benefits.
- copies of all records that may be requested concerning me or my family members, and
- non-medical information about me or my family members.

The term person or organization, which is used above, means a physician or medical practitioner, a hospital, clinic or other medical treatment facility, any insurance or reinsurance company, insurance support or reporting agency, pharmacy, government agency, or employer.

I understand that the information obtained by use of this authorization will be used by UnumProvident to determine eligibility for insurance and eligibility for benefits. UnumProvident will not release any of the obtained information to any other person or organization except reinsuring companies or other persons or organizations performing services in connection with my application or claim.

I understand that this authorization shall be valid for two years from the date shown on the application and that a photographic copy of this authorization shall be as valid as the original. I understand that I have the right to revoke this authorization at any time except to the extent it has been relied on prior to written notice of revocation. I also understand that, if I revoke this authorization, such revocation may be a basis for denying insurance benefits. This authorization may be revoked by sending written notice to: UnumProvident, Attn: Group Medical Underwriting, P.O. Box 9783-5083, Portland ME 04104.

The statements I have made on this application are true to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the group policy for which Evidence of Insurability is required. I have read and understand the Authorization and I have a right to receive a copy. I understand that failure to sign this Authorization may impair UnumProvident's ability to process my application or evaluate a claim, and that this may be a basis for denying my application or claim for benefits.

CAUTION: If your answers on the application are incorrect or untrue, UnumProvident may deny benefits or rescind your insurance. 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.

Employee Signature

Date

Spouse Signature

Date

Child Signature (if 18 or older)

Date



UnumProvident's Commitment to Privacy

UnumProvident understands your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

Collecting Information

We collect 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.

Sharing Information

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) with 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.

UnumProvident 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.

Safeguarding Information

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.

Access to Information

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.

Correction of Information

If you believe NPI we have about you is incorrect, please write to 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.

Coverage Decisions

If we decide not to issue 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.

Contacting Us

For additional information about UnumProvident's commitment to privacy, please visit www.unumprovident.com/privacy or www.coloniallife.com or write to: Privacy Officer, UnumProvident Corporation, 2211 Congress Street, M347, Portland, Maine 04122. We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

UnumProvident Corporation is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and The Paul Revere Variable Annuity Insurance Company.