DECLARATION, AGREEMENT AND AUTHORIZATION

I agree with the following statements:

1. The statements and answers in this application are true and complete and correctly recorded. I understand that they will become part of My application and any policies issued on it. If My answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind My coverage.

2. No broker has authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.

3. The insurance applied for will take effect if one of the following conditions occur:
   a. If the employer is paying the premium, immediately upon the date You fully complete and sign Your application provided You qualify for coverage under the terms and conditions of the offer; or
   b. If You are paying the premium, the first of the month in which premiums are deducted after approval of Your application. (If the application is fully completed and signed after the first of the month in which deductions begin, coverage will be effective on the date of the application.) The only exceptions to this are provided in the written agreement between the Company and employer as payor of policy or payroll deduction administrator.

4. I have received a copy of the Notice of Information Practices (including Medical Information Bureau notice and additional information required by the Fair Credit Reporting Act).

5. 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 of 1974 (ERISA), I acknowledge that my employer delegates the Company, acting through its agents, discretionary authority to make benefit determinations, resolve factual disputes, and interpret provisions of the plan. I will be entitled to appeal any benefit determination made by the Company that I disagree with pursuant to ERISA.

6. I HAVE BEEN INFORMED that any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be prosecuted for insurance fraud.

Disclosure Authorization

I AUTHORIZE: any doctor, hospital, clinic, provider of health care, insurance (or reinsuring) company, Medical Information Bureau Group, Inc., My insurance agents, employers or any other medical or medically related facility having: (i) information as to cause, treatment, diagnosis, prognosis or advice of My physical or mental condition; or (ii) any other financial or medical information needed to determine My eligibility for insurance; to give Unum and its affiliates and its employees and agents or My broker, all such information. This may include (but is not limited to) information about mental illness, and use of alcohol or drugs. I authorize Unum to give MIB Group, Inc. a report of this information. A photocopy of this authorization is valid. I or My authorized representative may request a copy of this authorization. This authorization will be in force for 24 months from the date shown below.

NOTICE OF INFORMATION PRACTICES

(Including Medical Information Bureau notice and additional information required by the Fair Credit Reporting Act)

This Notice must be given to Proposed Insured

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 GROUP, 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 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. The website address is www.mib.com.
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.

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.