

**TO TERMINATE YOUR INDIVIDUAL VOLUNTARY  
WHOLE LIFE OR CRITICAL ILLNESS POLICY WITH  
UNUMPROVIDENT**

1. Complete the attached “*Customer Service Request*” form. You are the Owner of the Policy, not DriveTime. Complete:
  - ❑ Top of form indicating who is the policyholder and their social security number. DriveTime is the Employer. There is no group number.
  - ❑ Check box #6, Surrender/Cancellation of Policy. You must also answer the bankruptcy question.
  - ❑ Check box #12 and sign name, provide social security number and date on form as requested. You must have someone witness your signature.
  - ❑ If you have a fax number or e-mail address, please provide this information in the space provided below the signature lines.
  
2. Fax this form to: Attn: David Mech, fax #423-294-2305.

Or mail form to: Attn: WDM, UnumProvident, One Fountain Square, Chattanooga, TN 37402

**PLEASE DO NOT SEND THIS FORM TO THE BENEFIT/PAYROLL DEPARTMENT.**

3. If questions, please call UnumProvident Customer Service at 800-635-5597.
  
4. Unum Provident will notify the DriveTime Payroll Department to stop any deductions. Any overpayments will be reimbursed to you directly by UnumProvident, not DriveTime.



CUSTOMER SERVICE REQUEST
VOLUNTARY WORKPLACE BENEFITS DIVISION

Provident Life and Accident Insurance Company
(Herein called Provident)
1 Fountain Square, Chattanooga, TN 37402

For toll free assistance call: 1-800-635-5597

The policyowner requests a change be made on one of the following policies:

Employee Spouse Child All Other (explain)

Confirm Policy # or Social Security #

Please confirm the name of your employer (Group Number if known)

1. Name Change of Insured Owner

From To

Reason for change: Marriage Court Order\* Adoption\* Correction\* Divorce\* Other\*

\*If name change is due to reason other than marriage or divorce, we will need a copy of the legal document for our records.

2. Owner's Current Mailing Address If New Address, Check Here Please confirm your current address

(Number/Street) (Street Address) (Apt. No.)
(City) (State) (Zip)

(Telephone Number)

Check this box if this is the only change you wish to make

3. Ownership Change Change the Owner to:

Name Soc. Sec. No.

Address

From the effective date hereof, the Owner designated above alone may exercise every privilege and enjoy every benefit granted under this policy to the Owner except that, if there is an irrevocably designated beneficiary, the Owner may exercise his/her rights only with the consent of such beneficiary. The rights of any deceased beneficiary shall vest in the Owner.

If Ownership Change is a result of the policyowner's death, we will need a copy of the Will or Letters Testamentary naming you as executor of the deceased's estate. If there is no Will or Letters Testamentary, you will need to contact our office at 1-800-635-5597.

Please note that completion of this section had no effect on the beneficiary designation. If a change of beneficiary is desired, complete section 8.

Request for Taxpayer (Owner's) Identification Number (in lieu Federal Form W-9)

Owner's Soc. Sec. No. or Employer's I.D. Number

Certification - Under the penalties of perjury, I certify that this is my correct Taxpayer Identification Number, and I am not subject to backup withholding. If you are subject to backup withholding, then place a check in the box.

Signature of New Owner Date

4. Contingent Owner Individual who will become policy owner if the primary owner is deceased.

Name No./Street City State Zip

5. Policy Loan Agreement MAXIMUM AMOUNT AVAILABLE, OR \$ CASH, OR FULL

AMOUNT AVAILABLE, IF LESS. In consideration of the advance by Provident of \$ as a loan, all right, title, and interest in the Policy, is hereby assigned to Provident as sole security for the repayment of the loan with interest, subject to the provisions of the Policy which are incorporated and made a part hereof.

Check box to confirm that no bankruptcy proceedings are now pending.



ELECTION OF FEDERAL INCOME TAX WITHHOLDING

Provident is required to withhold 10% of the taxable portion of the surrender unless you direct otherwise.

Even if you elect to not have Federal income tax withheld, you are liable for payment of Federal income tax on the taxable portion of your distribution. You also may be subject to tax penalties under the estimated tax portion of your distribution. You also may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate.

I agree "NO". I do not want Provident to withhold Federal income tax.

6.  **Surrender/Cancellation of Policy** You may surrender your policy for the cash surrender value, if any, otherwise your policy will be cancelled. By electing this option, you surrender the policy and all claims thereunder. If your policy has cash value, a check will be forwarded for the proceeds after deduction of indebtedness and/or applicable surrender charges, if any.  
 Check box to confirm that no bankruptcy proceedings are now pending.

7.  **Request for Duplicate Policy or Summary** This policy was lost or destroyed. \$25.00 Charge for duplicate policies.

8.  **Beneficiary Change(s)** Full given name, address, relationship and percentage must be given to be processed. If you are naming a minor child, you **MUST** include their date of birth. When naming a trust, you **MUST** include the name and date of trust. Unless otherwise specified, proceeds are to be paid in equal shares to the surviving beneficiaries, if more than one.

Primary					Percent	Relationship To Insured
Name	No./Street	City	State	Zip	%	
Name	No./Street	City	State	Zip	%	
Contingent					Percent	Relationship To Insured
Name	No./Street	City	State	Zip	%	
Name	No./Street	City	State	Zip	%	

9.  **Coverage Changes**

FROM (OLD POLICY)	TO (NEW POLICY)
Plan _____	Plan _____
Premium \$ _____	Premium \$ _____
Amount \$ _____	Amount \$ _____
Benefits _____	Benefits _____
Riders _____	Riders _____
Non Forfeiture Option: <input type="checkbox"/> APL <input type="checkbox"/> Reduced Paid Up	Non Forfeiture Option: _____    Effective Date _____ <input type="checkbox"/> APL <input type="checkbox"/> Reduced Paid Up

10.  **Policy Assignment Release** The undersigned (No. 12) assignee releases all rights, title, and interest in this policy

11.  **Additional Changes**

12.  **Signatures** Provident is hereby authorized to amend this request to correct obvious errors or omissions. If you live in a community property state, your spouse or ex-spouse **MUST** also sign this form. An adult other than a relative or beneficiary **MUST** witness your signature.

Owner Signature	Owner Soc. Sec. No.	Witness Signature	Date
Spouse Signature	Spouse Soc. Sec. No.	Witness Signature	Date
Assignee Signature	Assignee Soc. Sec. No.	Witness Signature	Date

( )

**Please include your fax # or email if you would like to receive an INSTANT CONFIRMATION of the changes made to your policy:** \_\_\_\_\_

**Acknowledged**

**THIS SECTION FOR PROVIDENT HOME OFFICE USE ONLY**

BY \_\_\_\_\_

DATE \_\_\_\_\_