

This information initiates Unum processing that ultimately produces your contract, employee booklets, and bills. We thank you for completing this information accurately and promptly returning it.

SECTION 1: Company information

Company Legal Name <i>(Please use punctuation and any abbreviations that apply)</i>		Employer Main Phone Number
Address		Employer Identification Number (EIN):
City	State/Province	State/Province of Jurisdiction (where corporate headquarters is located)
Zip/Postal Code	Country	
Nature of Business (please specify):		Number of Years in Business
Are U.S. employees in other states or countries covered? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, List employees by state and country on census)		Are foreign nationals covered under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, List employees by state and country on census)

Does the company participate in a Workers' Comp/PERA/PERS Program?
 Yes No

Are other divisions, subsidiaries, or affiliates covered under this plan?
 Yes No (If Yes, attach name, address, relationship and nature of business)

Does the company have employees working in locations other than the city/state where the Master application was signed? Yes No

Are employees in these other locations to be covered by this policy?
 Yes No

If you answered "Yes" to the last two questions, complete the final page of this form, "Important Company Location Information."

SECTION 2: Type of Organization

<input type="checkbox"/> Regular C-Corporation (1120)	<input type="checkbox"/> Sole Proprietorship (1040, Schedule C)	<input type="checkbox"/> Government Organization
<input type="checkbox"/> Subchapter S-Corporation (1120S)	<input type="checkbox"/> Trust	<input type="checkbox"/> Non-Profit Organization (990)
<input type="checkbox"/> Partnership (1065)	<input type="checkbox"/> School or Municipality	<input type="checkbox"/> Other (Please Specify) _____
<input type="checkbox"/> Limited Liability Company (1065)*	<input type="checkbox"/> Association	
<input type="checkbox"/> Limited Liability Partnership (1065)*	<input type="checkbox"/> Union	

*Indicate IRS tax form filed if not 1065 _____

SECTION 3: ERISA Information

Plan Name	Plan Number
Plan Year Ends	Employer Phone Number

SECTION 4: Contacts

Decision-maker for company's employee benefits	Telephone Number
E-mail Address	Fax Number
Plan Administrator/Correspondent Name <i>(if different than above)</i>	Telephone Number
E-mail Address	Fax Number
Claims Contact <i>(if different than above)</i>	Telephone Number
E-mail Address	Fax Number
Billing Contact <i>(if different than above)</i>	Telephone Number
E-mail Address	Fax Number
Does your Company utilize a Third Party Administrator? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Third Party Administrator's Name	Telephone Number
E-mail Address	Fax Number

SECTION 5: Eligibility Information

Description of eligible employees	Number of eligible employees
Minimum number of hours the employee must work to be covered	
Are any employees excluded? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, who?	Is there anyone not actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, who?
Are any dependents disabled under Life plans? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, who?	
Is Board of Directors included? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Canadian Employees:	
Does the company employ residents of Canada? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, are the employees covered under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
Waiting Period: Present Employees:	
Are all current employees covered as of the effective date? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, do they have the same waiting period as future hires? <input type="checkbox"/> Yes <input type="checkbox"/> No
Waiting Period: Future Employees:	
<input type="checkbox"/> No Waiting Period	
1st of the month coinciding with or next following: <input type="checkbox"/> ___ day(s) of active employment OR <input type="checkbox"/> ___ month(s) of active employment	The day following completion of: <input type="checkbox"/> ___ day(s) of active employment OR <input type="checkbox"/> ___ month(s) of active employment
Payroll billed cases only — First pay period following: <input type="checkbox"/> ___ day(s) of active employment OR <input type="checkbox"/> ___ month(s) of active employment	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> Other, please specify _____

Credit Prior Service: Does prior service apply? Yes No

If policyholder wants to credit time in an eligible or ineligible class toward meeting the waiting period, select Yes.

For Long Term Care Coverage ONLY – Terminated Employees Terminate Coverage on:

Termination Date End of Month End of Payroll Period (if payroll billing selected)

Domestic Partner (Life coverage requires Underwriting approval) Yes No

SECTION 6: Contributions - Check one of the following and complete the applicable questions.

- Your company (the employer) pays 100% of the plan premiums
Are Owners covered under the plan? Yes No
- Your employees pay 100% of the plan premiums
Are employee-paid premiums paid through a Section 125 plan? (Not applicable for LTC) Yes No
- Both the employer and the employee share the funding of the plan premiums
Indicate percentage of the contribution paid by the employer: _____ %
- Your company (the employer) funds base plan with employee buy-ups. Are employee-paid premiums through a Section 125 plan? (Not applicable for LTC) Yes No
Indicate percentage of the contribution paid by the employer: _____ % for employee coverage
_____ % for dependent coverage
- Is participation mandatory? Yes No
If No, have participation requirements been met? Yes No

Tax Choice questions are applicable for Group Long Term Disability and Short Term Disability products.

Does your company's (the employer's) **disability plan** provide for the choice between having premiums paid on a fully pre-tax or fully post-tax basis at the election of the employee or the employer? **Note:** An additional cost may be associated with Tax Choice options.*

If yes, check one of the following premium funding arrangements which describes the tax choice plan design that your company (the employer) has selected:

- The Employer pays 100% of the premium and includes this contribution in the Employee's taxable income (i.e. mandatory "gross up").
- The Employer pays 100% of the premium and each Employee is offered the choice of whether to have premium included in the Employee's taxable income (i.e. elective "gross up").
- The Employee pays 100% of the premium and each Employee is offered the choice of whether to have premium deducted on a pre-tax basis (inside a Section 125 plan) or on a post-tax basis.
- The Employer has a base/buy-up plan where the Employer and the Employee share in the funding of the plan that offers a choice of having premium paid on a fully pre-tax basis or a fully post-tax basis.
- Other. Please describe _____
- Does the tax choice plan design apply to all employees or a class of employees? Please explain.

*** If your LTD or STD contract does not currently have a Tax Choice option and you would like to have it added, this could result in an increase in the sold rate.**

SECTION 7: Insured Earnings Definition

(please complete thoroughly as benefits and premiums will be based on this information): (Not Applicable for LTC)

- Salary Only
- Prior Year W-2
- Prior Year W-2 Without Bonuses
- Salary & Bonuses*
- Salary & Commissions
- Salary, Commissions & Bonuses
- Salary & Overtime
- Partners - Prior Year K-1
- Subchapter S Corporation
- Sole Proprietorship
- Teachers Contract (1/12th of annual contract salary)
- Teachers Contract (1/9th or 1/10th of contract salary)
- Other Insured Earnings Definition (please specify) _____

Do earnings reported as salary include contributions to a Qualified Deferred Compensation plan? Yes No
 Do earnings reported as salary include contributions to a Section 125 Plan or Flexible spending account? . Yes No
 If earnings differ by employee group(s), class(es), or division(s), please specify differences below: _____

***Bonus Questionnaire:** (only complete this section if the plan's Insured Earnings Definition includes bonuses)

Is bonus based on a pre-determined formula? Yes No
 If Yes, is the formula/payment of the bonus based on:
 Company performance (describe criteria) _____
 Individual performance (describe criteria) _____
 A combination of individual & company performance (describe criteria) _____
 Criteria: _____

Indicate the percentage of each: ___% individual performance ___% company performance
 How long has the bonus plan been in effect? _____
 How many times has the bonus been paid? _____
 Does the company plan to continue the bonus plan indefinitely? Yes No
 Who is eligible for the bonus? _____
 Are disabled employees eligible for the bonus? Yes No
 If Yes, are they eligible only in the year in which they last worked? Yes No
 If No, please explain _____

SECTION 8: Prior Plan Information

Does this plan replace other coverage? Yes No
 If so, attach a copy of the prior plan's contract or employee booklet and complete the following:

Coverage	Effective Date	Termination Date	Prior Carrier Name
Long Term Disability			
Short Term Disability			
Life (and/or Life AD&D)			
Long Term Care			

SECTION 9: STD

For STD Only: (Not applicable for LTC)

To whom are STD benefits check payable? Employee Employer

STD FICA Match: (there is an additional cost for this service) Yes No
 Effective Date _____

Statutory Coverage:

Please indicate if the company has employees who work in any of the following states.*

- New York
- Hawaii
- Rhode Island
- New Jersey
- California
- Puerto Rico

If so, are these employees covered under this plan? Yes No
 If yes, are these employees covered under the Statutory plan? Yes No

*The states listed above have special requirements for disability coverage which your Unum contract may not satisfy.

Are any entities filed as a "Plan or Agreement"? If so, provide the DB-801 or DB-802 form as documentation for proper state filing.

SECTION 13: Important Company Location Information

Company location information is imperative. If the company has subsidiaries filed with their own FEIN with current employees working in the provided location, complete the following in detail.

1) (Main situs) Company Name and FEIN Number

Address

Relationship & Nature of Business

2) Company Name and FEIN Number

Address

Relationship & Nature of Business

3) Company Name and FEIN Number

Address

Relationship & Nature of Business

4) Company Name and FEIN Number

Address

Relationship & Nature of Business

If there are more than four locations to be covered, please continue on another sheet. List the same information as requested above. Locations within the same state but not at the same address must be noted separately.

Once you have listed all locations to be covered by this policy, indicate on your census which employees work at which location, using the numbers relevant to each location's information. **See this example of Company Location and Census Coding:**

1) (Main situs)

Company Name: Excellent Ice Cream Company
 Address: 999 Central Road, Someplace, New Jersey 07000
 Nature of Business: Food Processing

2) (Second Location in another state)

Company Name: Excellent Ice Cream Delivery
 Address: 222 Ice Cream Lane, Someplace, Delaware 19700
 Nature of Business: Trucking/No Warehousing

3) (Third Location also in same state as second location, but at a different address)

Company Name: Excellent Ice Cream Packaging
 Address: 444 Dairy Road, Someplace Else, Delaware 19701
 Nature of Business: Food Product Packaging

LAST NAME	FIRST NAME	GENDER	SSN	OCCUPATION	DOB	DOH	ANN SAL	HRS/WK	LOC #
Doe	John	M	999-99-9999	President	07/09/1956	01/01/1986	75000	40	1
Doe	Jane	F	888-88-8888	Vice President	01/02/1964	01/01/1986	50000	40	2
Fox	James	M	777-77-7777	Truck Driver	08/03/1963	01/01/1985	40000	40	2
Employee	Joe	M	666-66-6666	Packer	06/22/1970	01/01/1999	30000	40	3

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