



**CLIENT INFORMATION**  
**First Unum Life Insurance Company**  
 2211 Congress Street  
 Portland, Maine 04122

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 <i>(If Yes, List employees by state and country on census)</i>	Are foreign nationals covered under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, List employees by state and country on census)</i>
--	--

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
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?
<b>Canadian Employees:</b>	
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
<b>Minimum number of hours the employee must work to be covered</b>	
<b>Waiting Period: Present Employees:</b>	
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
If not all employees are being covered, does prior service apply? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Waiting Period: Future Employees:</b>	
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 _____
<b>Credit Prior Service:</b> If not all employees are being covered, does prior service apply? <input type="checkbox"/> Yes <input type="checkbox"/> No If policyholder wants to credit time in an eligible class toward meeting the waiting period, select Yes.	
<b>Terminated Employees Terminate Coverage On:</b> (For Long Term Care coverage only) <input type="checkbox"/> Termination Date <input type="checkbox"/> End of Month <input type="checkbox"/> End of Payroll Period (if payroll billing selected)	



**SECTION 8: Insured Earnings Definition**

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

- Salary Only
- W-2 Earnings Calendar Year
- W-2 Earnings 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) \_\_\_\_\_

Are contributions to a qualified Deferred Compensation Plan to be included? .....  Yes  No  
 Are contributions to a Section 125 Plan or flexible spending account to be included? .....  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 9: 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 10: 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

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



## SECTION 14: Important Company Location Information

Company location information is imperative. If the company has locations in cities/states other than where the Master Application was signed and these locations are covered by the policy, complete the following in detail.

1) (Main situs) Company Name

Address

Relationship & Nature of Business

2) Company Name

Address

Relationship & Nature of Business

3) Company Name

Address

Relationship & Nature of Business

4) Company Name

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

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.