



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>
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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?

 Yes 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
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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?
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Canadian Employees:

Does the company employ residents of Canada?

 Yes No

If Yes, are the employees covered under this plan?

 Yes No**Minimum number of hours the employee must work to be covered****Waiting Period: Present Employees:**

Are all current employees covered as of the effective date?

 Yes No

If no, do they have the same waiting period as future hires?

 Yes No

If not all employees are being covered, does prior service apply?

 Yes No**Waiting Period: Future Employees:**

1st of the month coinciding with or next following:

 ___ day(s) of active employment OR ___ month(s) of active employment

The day following completion of:

 ___ day(s) of active employment OR ___ month(s) of active employment

Payroll billed cases only — First pay period following:

 ___ day(s) of active employment OR ___ month(s) of active employment No Waiting Period Other, please specify**Credit Prior Service:** If not all employees are being covered, does prior service apply? Yes No

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

Terminated Employees Terminate Coverage On: (For Long Term Care coverage only) Termination Date End of Month End of Payroll Period (if payroll billing selected)

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 your company and your employees share in payment of the plan premiums
Are employee-paid premiums paid 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
Domestic Partner (Life coverage requires Underwriting approval) Yes No

SECTION 7: Tax Choice Plan Options

(Not applicable for Life/AD&D, Long Term Care and Select Income Protection)

Complete this section only if your company's (the employer's) disability plan provides 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 these options.

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

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

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