Long Term Disability Employee Listing

Please Type or Print Clearly

Policyholder Name ____________________ Policy Number ____________ Division ____________

City ____________ State ______ Zip ________ Listing as of (date) __ __ /__ __ /__ __ __ __ Prepared By ____________ Phone Number ____________

☐ **NONCONTRIBUTORY**

☐ **CONTRIBUTORY**[1]

[1] - **IF YOUR PLAN IS CONTRIBUTORY PLEASE LIST ALL ELIGIBLE EMPLOYEES AND INDICATE ENROLLED STATUS WITH A Y (YES) OR N (NO).**

Employee Name (last, first, middle initial)	Occupation/Job Title	For Unum Use Only	Employee Class[3]	Social Security Number	Sex	Date of Birth (MM/DD/YYYY)	Basic Monthly Earnings[2]	Hrs Worked Per Week	Date of Hire (MM/DD/YYYY)	Enrolled Y/N
EXAMPLE: Doe, John J.	VP Marketing			005-19-4501	M	01/05/1940	2,000	30	01/01/1965	Y
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LISTING CONTINUES ON REVERSE SIDE

[2] - Basic Monthly Earnings is the amount of income covered by this policy. Please refer to your contract for income definition.

[3] - Employee Class: Your plan may have separate classes for benefits or eligibility. Please indicate class for each employee.

Employee Name (last, first, middle initial)	Occupation/Job Title	For Unum Use Only	Employee Class[3]	Social Security Number	Sex	Date of Birth (MM/DD/YYYY)	Basic Monthly Earnings[2]	Hrs Worked Per Week	Date of Hire (MM/DD/YYYY)	Enrolled Y/N
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