Client Information

First Unum Life Insurance Company
99 Park Avenue, 6th Floor, New York, NY 10016

Because this information initiates UnumProvident processing that ultimately produces your contract, employee booklets, and bills, it is important that you complete this information accurately and promptly return it.

The Company's Legal Name (please use punctuation and any abbreviations that apply):

____

Address ____

City ______________________ State/Province ______________________

Zip/Postal Code ______________________ Country ______________________

Employer Identification Number (EIN): ______________________
ERISA Plan Name: ______________________
ERISA Plan Number: ______________________
ERISA Plan Year Ends: ______________________
ERISA Employer Phone Number: ______________________

State/Province of Jurisdiction (where the corporate headquarters is located): ______________________

Are other divisions, subsidiaries, or affiliates covered under this plan? ☐ No ☐ Yes

If Yes, attach name, address, relationship and nature of business.

Decision-maker for company's employee benefits: ______________________

Telephone Number (   ) ______________________ Fax Number (   ) ______________________

E-mail Address ______________________

Plan Administrator/Correspondent Name (if different than above): ______________________

Telephone Number (   ) ______________________ Fax Number (   ) ______________________

E-mail Address ______________________

Claims Contact (if different than above): ______________________

Telephone Number (   ) ______________________ Fax Number (   ) ______________________

E-mail Address ______________________

Billing Contact (if different than above): ______________________

Telephone Number (   ) ______________________ Fax Number (   ) ______________________

E-mail Address ______________________

☐ Self Accounting ☐ List Bill

Does your Company utilize a Third Party Administrator? ☐ No ☐ Yes

Third Party Administrator's Name ______________________

Telephone Number (   ) ______________________ Fax Number (   ) ______________________

E-mail Address ______________________

Description of eligible employees: ______________________

Number of eligible employees ______________________

Are any employees excluded? ☐ No ☐ Yes

If Yes, who? ______________________

Minimum number of hours the employee must work to be covered: ______________________

Organization Type (IRS tax form filed)
☐ Regular C-Corporation (1120)
☐ Subchapter S-Corporation (1120S)
☐ Partnership (1065)
☐ Limited Liability Company (1065)*
☐ Limited Liability Partnership (1065)*
☐ Sole Proprietorship (1040, Schedule C)

*indicate IRS tax form filed if not 1065 ____________________.

Other Organization Types:
☐ Trust
☐ School or Municipality
☐ Association
☐ Union
☐ Government Organization
☐ Nonprofit Organization (990)

Client Info (page 2)

Nature of Business (please specify): ____________________

Are U.S. employees in other states or countries covered? ☐ No ☐ Yes (If Yes, List employees by state & country on census)
Are foreign nationals covered under this plan? ☐ No ☐ Yes (If Yes, List employees by state & country on census)
Does the company participate in a Workers' Comp/PERA/PERS Program? ☐ No ☐ Yes

Canadian Employees:
Does the company employ residents of Canada? ☐ No ☐ Yes
If Yes, are the employees covered under this plan? ☐ No ☐ Yes

Waiting Period:
Present Employees: Are all current employees covered as of the effective date? ☐ No ☐ Yes
If no, do they have the same waiting period as future hires? ☐ No ☐ Yes
If not all employees are being covered, does prior service apply? ☐ No ☐ Yes

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 ____________________

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? ☐ No ☐ Yes

☐ Your employees pay 100% of the plan premiums
Are employee-paid premiums paid through a Section 125 plan? (Not applicable for LTC) ☐ No ☐ Yes

☐ Both your company (the employer) and the employees share in the funding of the plan premiums ☐ No ☐ Yes

Are employee-paid premiums paid through a Section 125 plan? (Not applicable for LTC) ☐ No ☐ Yes

Indicate percentage of the contribution paid by the employer:
_____% for employee coverage
_____% for dependent coverage

☐ Other. Please describe ____________________

Participation:
Is participation mandatory? ☐ No ☐ Yes
If No, have participation requirements been met? ☐ No ☐ Yes

Tax Choice Plan Options: (Not applicable for LTC)
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.

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 ____________________

Client Info (page 3)

Insured Earnings Definition ***(please complete thoroughly as benefits will be based on this information) : (Not Applicable for LTC)***

☐ W-2 Earnings Calendar Year ☐ Salary Only ☐ Salary & Commissions ☐ Salary & Bonuses* ☐ Salary, Commissions & Bonuses*

☐ Partners - Prior Year K-1 ☐ Partnership Agreement (1/12th of budgeted annual earnings) ☐ Sole Proprietorship ☐ Subchapter S Corporation

☐ Teachers Contract (1/12th of annual contract salary)

☐ Other Insured Earnings Definition (please specify) ______________________________

Are contributions to a qualified Deferred Compensation Plan to be included? ☐ No ☐ Yes

Are contributions to a Section 125 Plan or flexible spending account to be included? ☐ No ☐ Yes

If earnings differ by employee group(s), class(es) or division(s), please specify difference below:

____

____

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

Is bonus based on a pre-determined formula? ☐ No ☐ Yes

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? ☐ No ☐ Yes
Who is eligible for the bonus? ______________________________
Are disabled employees eligible for the bonus? ☐ No ☐ Yes
If Yes, are they eligible only in the year in which they last worked? ☐ No ☐ Yes
If No, please explain ______________________________

Prior Plan Information:
Does this plan replace other coverage? ☐ No ☐ Yes
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			

For STD Only: (Not applicable for LTC)
To whom are STD benefits check payable? ______________________________

Statutory Coverage:
Please indicate if the company has employees who work in any of the following states.
☐ New York ☐ New Jersey
☐ Hawaii ☐ California
☐ Rhode Island ☐ Puerto Rico
If so, are these employees covered under this plan? ☐ No ☐ Yes (If Yes, see procedures for statutory plan requirements

DBL Coverage:
Is the company sitused in New York? ☐ No ☐ Yes
If Yes, are there also employees working outside of New York? ☐ No ☐ Yes (If Yes and DBL coverage, see procedures for DBL requirements/processing)

Client Info (page 4)

Internet Services: For access to online services we need the following registration information:
☐ Internet access available
☐ Customer is using an IBM compatible PC (Apple computers are not compatible with UnumProvident's Internet Services)
☐ Customer is using the Windows Operating System (e.g., 95, 98, NT, ME, 2000, XP)
☐ Customer is using Internet Explorer browser version 5.5 or higher or Netscape browser version 6.0 or higher.

Site Administrator's Full Name ______________________________

The person listed will be granted access to the website and will have the capability of registering additional users for access to the company's security information.

Work Telephone Number ______________________________

E-mail Address (becomes website User Name):______________________________

The e-mail address listed will become your user name for log-in to the site and will receive a notification whenever a new bill is posted to the website.

Mother's Maiden Name:______________________________

This information will be used for security verification if you need to reset your password on the website. It is important that you enter the information on this form exactly as you would like to enter it on the website, should you forget your password and need a new one.

Booklet Distribution: (Check One)
☐ I-Booklet ☐ E-mail E-mail Address ______________________________
Note: Employee booklets are provided to you via e-mail or i-booklet. This enables you to distribute the booklets to your employees via e-mail or from your company's intranet site, so long as you can comply with the Department of Labor's electronic delivery requirements. If none of the above distribution options meet your needs, please contact your UnumProvident representative.

Acknowledgement:
Effective Date for UnumProvident Plan: ____________ Anniversary Date for UnumProvident Plan: ____________
Please Confirm Sold rate(s):

LTD ____________ Life ____________ AD&D ____________ Dependent Life ____________

STD ____________ LTC ____________

Your Name ______________________________

Signature ______________________________

Date ______________________________