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LONG TERM DISABILITY PLAN

Liberty Mutual Life Insurance Company of America

I hereby certify that I was previously employed by:

(Name of Previous Employer)

and was covered under their long term disability program, which provided income benefits for a minimum of five years of disability, as indicated below:

INSURANCE COMPANY: _____

DATE COVERAGE TERMINATED: _____

Employee Name: _____
(Please Print)

Social Security Number: _____

Signature: _____ Date: _____