# LONG TERM DISABILITY PLAN

I hereby certify that I was previously employed by:

________________________________________________________________________

(Name of Previous Employer)

and I 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)

BU ID Number: __________________________________________________________

Signature: ________________________________________ Date: ____________________

Please return this form to Human Resources, 25 Buick Street, Boston, MA 02215 or by fax to 888-975-1568 within 90 days of termination of your previous employer's coverage.