

CERTIFICATION OF PREVIOUS COVERAGE

I hereby certify that I was previously employed by:

(Name of Previous Employer)

and was covered under their staff benefit plan(s) as indicated below:

Coverage	Insurance Company	Date Coverage Terminated
Group Total Disability (providing income benefits for a minimum of 5 yrs. for total disability)		
Life Insurance-Wholesale or Group		

(Name of Current Employer)

(TIAA Policy Number)

Date _____ Signature _____