CERTIFICATION OF PREVIOUS GROUP LONG-TERM DISABILITY 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 of Coverage Terminated
Group Total Disability **(providing income benefits for a minimum of 5yrs. for total disability)**		

___________________________ ___________________________

(Name of Employee) ***(Banner Number)***

Date:__________________ **Signature:** ______________________________