

Health & productivity in the aging American work force: realities and opportunities

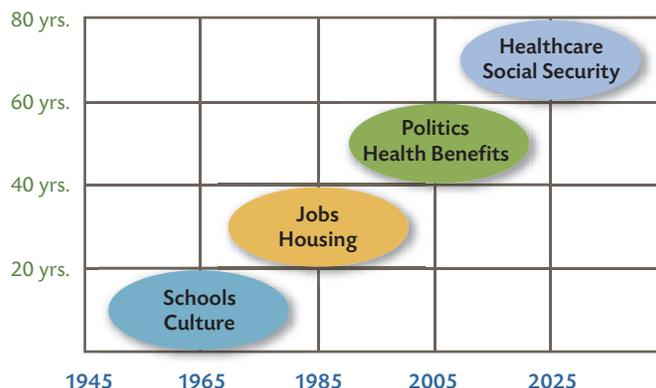
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Over the next two decades (2005 – 2025), the American work force, as well as other industrialized countries, will be significantly influenced by the cohort of individuals born between 1946 – 1964, i.e. the “baby boomers.” This group includes an estimated 78-million individuals in the U.S. who will be 40 – 60 years of age in 2006.

Employers will be challenged to manage both the larger group of older workers, and at the same time address the projected labor and talent shortages caused from the reduced number of available workers in the wake of the boomer-age bubble. Figure 1.1 illustrates the age bubble and the respective impact it has and will have.

Fig. 1.1 – The baby boomer age bubble



The members of the baby boom generation have dominated and realigned cultural mores, lifestyles, politics, education resources, consumer patterns and the respective economies as they have progressed through their life phases. As the baby boom bubble ages, employers should expect them to impact the workplace – from physical work requirements, to benefits to productivity – in a variety of ways.

This publication sets the foundation for a wide range of corporate policy considerations, benefits and healthcare services and individual priorities of the baby boomer work force.

Data for this publication, unless otherwise referenced, was generated using UnumProvident’s disability database, the leading disability database in the nation.

Realities of the aging worker

Age is not a disability.
Aging is not a disease.

The “new” older work force will place unique demands and challenges on corporate managers, human resources, occupational health and employee relations professionals.

The Society for Human Resources (SHRM) reports in its *2004 – 2005 Work Place Forecast, a Strategic Outlook*, a number of key demographic trends for which human resource managers need to prepare. They are:

- aging of the workforce
- growth in the number of workers with elder care responsibilities
- growth in the number of employees with both child care and elder care responsibilities
- generational conflict
- increase in age discrimination litigation

The senior worker is subjected to many stereotypes within the work place. The notion of “working but retired,” “light duty as a career path,” and the common thinking that “you can’t teach old dogs new tricks” can influence management decisions and employee relations. There are emerging corporate realities to consider. They are:

Emerging corporate realities:

- Individuals looking to work beyond traditional retirement years
- Employers needing individuals to work beyond traditional retirement years
- Intergenerational partnering as an expected corporate function
- Increased demand for unique transitions from work to retirement
- Attention to the prevention and management of chronic disease and impairment
- Increased demand for healthcare benefits for retired workers

The health and productivity picture of the worker over the age of 40 includes a variety of distinct realities connected with the physical, cognitive and emotional work capacities of the older worker.

The impact of aging on an individual’s functional work capacity is not uniform, not the same for all. Getting older by itself creates a wide range of potential health and productivity predicaments that demand a response from employers, medical providers and the worker. The first step in developing and applying strategies that protect the productivity of the older worker is understanding the nature and scope of the worker’s medical condition, its temporary or long term impact on work capacity, and the strategies that can be applied in a timely fashion to maintain that employee’s work capacity.

“I keep trying to retire from everything, and I discover I’ve retired from absolutely nothing.”

Paul Newman, age 80, actor

The following health and productivity snapshots serve as a starting point:

- **Lost time incidences** – Workers over the age of 40 have lower incidence of work injuries, short term disability and unscheduled absences than the employee under the age of 40.
- **Extended time off** – Workers over the age of 40 experience greater time off from work when an injury or illness occurs. Seventy-six percent of UnumProvident’s long term disability cases are over the age of 40, with the 35% target group between the ages of 50 and 59.
- **Learning new skills** – Contrary to the notion that old dogs cannot learn new tricks, the worker over the age of 40 is able to adapt and learn new situations, but does so as a function of well defined training and education programs. This learning is significantly influenced by personal choices to learn or not, relevant or not. The ability of many workers over the age of 50 to engage in high-speed problem solving/repetitive tasks is diminished from the younger worker.
- **Physical endurance** – The worker over the age of 50 typically responds poorly to heavy continuous efforts with well defined and enforced (i.e. no cheating) high work rates. Job experience typically mitigates the changing or eroding physical capacities in relation to maintaining appropriate levels of productivity.
- **Environmental conditions** – Exposure to high thermal stress reduces work performance. Sensory functions and muscular strength typically diminish after the age of 50. Visual acuity and close reading functions tend to erode after the mid 40s.
- **Personality Development** – Increased age-related intellectual and personality development improves work efficiencies and offers an increased success in decision-making.
- **Job satisfaction** – Job satisfaction or lack thereof offers differential impact on productivity more so than the younger worker. SHRM reports that employees in their mid 50s and older have a reported higher job satisfaction than that of the younger worker and that the “very important” aspects of their jobs are benefits, feeling safe at work and job security.
- **Age and medical costs** – Medical costs are reported to rise at an estimated 25% from age 40 to 50 and 35% from age 50 to 60. Age is less a factor in health care costs than the presence of such risk factors as smoking, obesity, lack of exercise, and diabetes.

Health, productivity and risk patterns in the boomer work force

Figure 2.1

A 55-year-old worker has a 30% lower risk of being injured on the job than a 30-year-old worker. This typically reflects a combination, over time, of worker migration to jobs with lower exposure to injury and to an increase in participation in safe work practices.

This data indicates that the Baby Boom generation may have already made its impact on work-related lost time, and that the older work force may produce lower injury rates going forward.

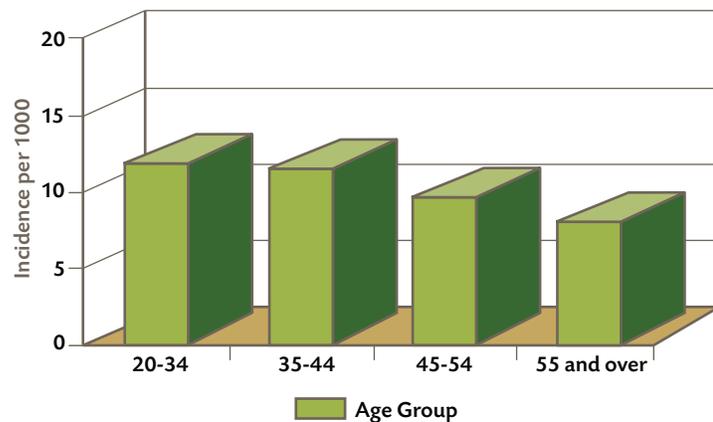
Figure 2.2

Older workers typically have more severe consequences and slower recovery rates after an injury or illness, increasing their number of lost days. This is particularly true for musculoskeletal injuries.

An additional factor to be considered is the rehabilitation practices of the physician and the corporate policies of the employer. If an incremental resumption of productivity is not part of the treatment process, the time required for an older worker to return to productivity can be extended by 20% to 30%. Incremental return-to-work procedures can reduce unnecessary lost time for the older worker.

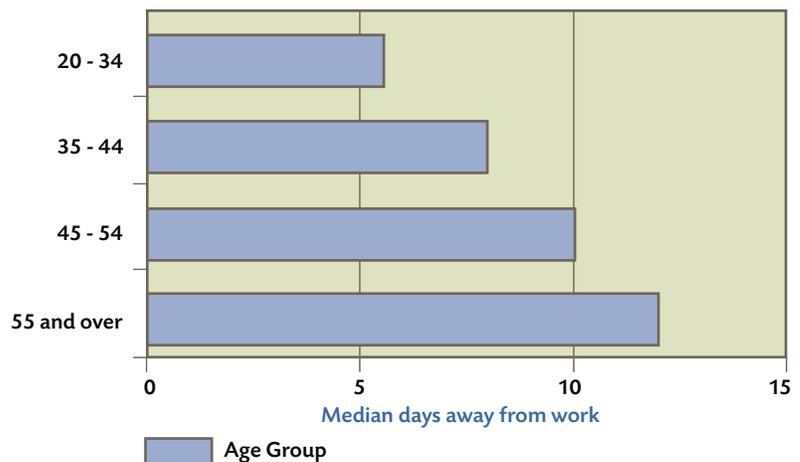
The worker over the age of 40 – and especially over the age of 50 – has unique health and productivity patterns that serve as the foundation for protecting their individual and collective productivity.

Fig. 2.1 – Work-related lost time claims by age group



Source: 2002/2003 Bureau of Labor Statistics & 2003 Current Population Survey, U.S. Department of Labor

Fig. 2.2 – Duration of work-related claims



Source: 2002/2003 Bureau of Labor Statistics & 2003 Current Population Survey, U.S. Department of Labor

Figure 2.3

According to UnumProvident’s data, workers over the age of 40 account for 50% of all received STD claims, and up to 75% of all received LTD claims. Thirty-four percent (34%) of LTD claims come from workers in the 50 – 59 age group.

This suggests that age becomes a factor in any return-to-work consideration when the corporate policy has an early threshold (e.g. 180 days of lost time) for termination from the organization.

It is important to note that only 12% of LTD claims are being generated by workers aged 60 or over. This suggests that those closest to expected retirement age (i.e. age 65) may have the least lost time. It also may reflect fewer numbers in the work force. This will change over the next decade.

Figure 2.4

Maternity claims serve as the primary STD lost time incident for employees under the age of 40. Not surprisingly, this is not the case for the older worker. Illness and chronic disease lead the primary group of lost time events for the older worker.

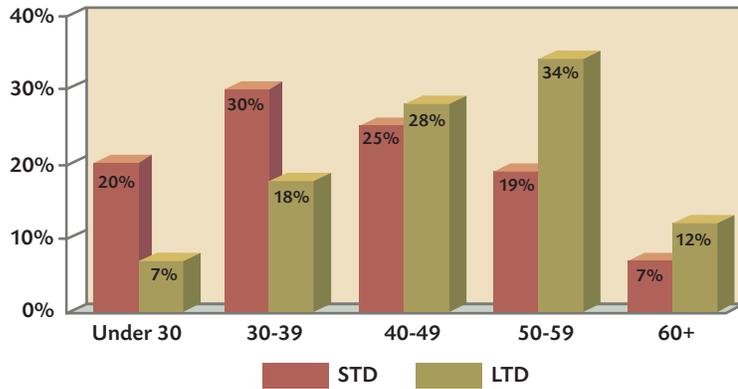
This pattern provides a clear focus for the employer and involved healthcare teams when supporting the over-40 worker’s efforts to maintain or return to full productivity. This also provides a foundation for the consideration of coupling disease and lost time management programs with the dual purpose of controlling healthcare costs and lost time.

Figure 2.5

The primary drivers of long term impairments and work disruptions for the older worker are musculo-skeletal disorders (accident/arthritis -25%), cancer (17%) and cardiovascular/ circulatory disorders (8%). Depression can also serve as a primary, as well as secondary driver of lost time and reduced productivity.

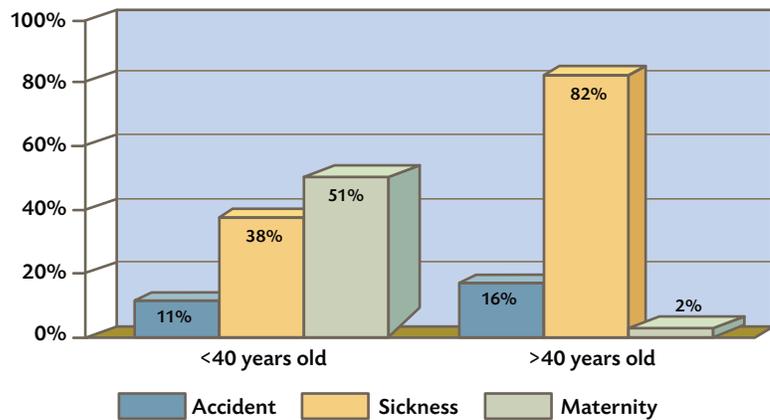
These patterns of impairment offer specific intervention points for employers trying to maintain work site productivity, and can guide them by focusing on “work prescriptions” for recuperating employees rather than on work restrictions and limitations.

Fig. 2.3 – Distribution of short (STD) and long (LTD) term disability by age



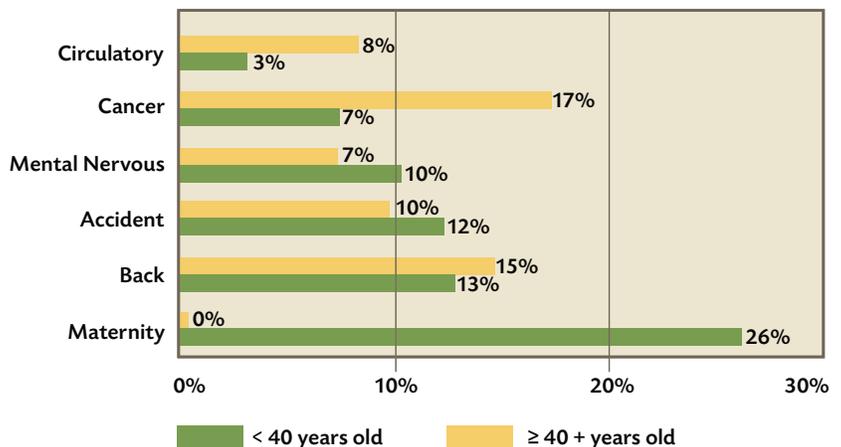
Source: UnumProvident Disability Database, 2002-2004.

Fig. 2.4 – Risk dynamics – STD by major impairment category



Source: UnumProvident Disability Database, 2002-2004.

Fig. 2.5 – Risk dynamics – most frequent long term impairments



Source: UnumProvident Disability Database, 2002-2004.

2 Section Two

Figure 2.6

Even within the senior work force there are differences in lost time. The employer and healthcare provider must work together to define the appropriate balance of desired work return options to minimize the length of time away from work.

For example, cancer and arthritis screening programs can become valuable work prescription starting points for employers, coupled with a more flexible work site capable of adapting to restrictions and limitations due to chemotherapy and/or chronic pain, which often result in intermittent or cyclic lost time.

Similarly, early intervention programs can assist the employer and employee alike, by defining the best pathways for an employee to return to full productivity. Additionally, appropriate work site accommodations and functional improvement programs can be applied to increase work capacity.

While the 60+ age segment has the lowest percentage of LTD cases, they also have the longest periods of lost time. This work disruption may be the bridge between work and retirement.

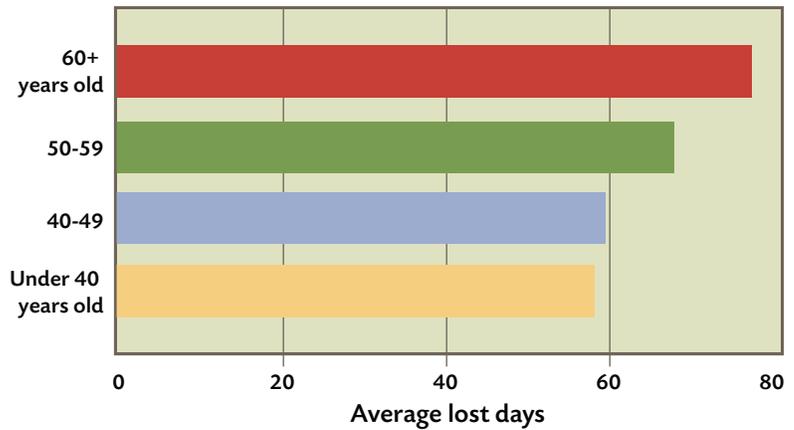
Figure 2.7

The distribution of top short term impairments across selected industries for the worker over age 40 offers guidance in program development. Consistently, musculoskeletal impairments dominate all industries, but are especially prevalent within the manufacturing and healthcare group.

Cancer and other metabolic disorders are strong overall contributors to lost time patterns, especially in education and transportation industries. For example, diabetes can have an impact on the licensing of commercial drivers in the transportation industry.

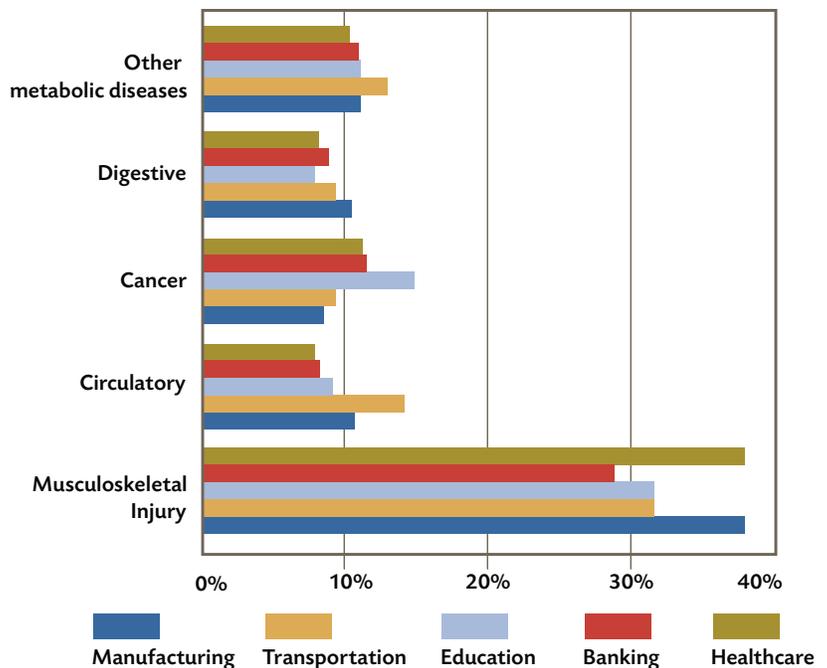
These well-defined incidence patterns suggest significant opportunities for industry-specific strategies to control healthcare costs and lost time. This may include partnerships with healthcare teams specializing in clinical best practices for these conditions. Correspondingly, employers and benefit groups may be able to develop improved alignment of benefit plans that support continued productivity for targeted high incidence impairments.

Fig. 2.6 – Risk dynamics – STD duration of lost time by age group



Source: UnumProvident Disability Database, 2002-2004.

Fig. 2.7 – Industry comparison – top short term impairments for workers over 40



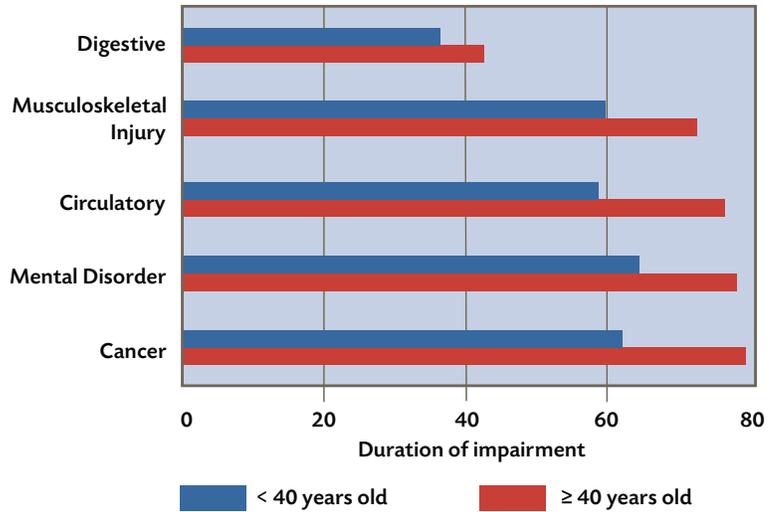
Source: UnumProvident Disability Database, 2002-2004.

Figure 2.8

Age appears to make a difference in the duration of impairments. The over-40 worker with musculoskeletal or injury impairment is reported to stay off work 12 days longer, on average, than a younger worker with a similar impairment. The other impairment groups show even greater differences.

Both the treatment and work site reengagement to full productivity should be specific and coordinated.

Fig 2.8 – Risk dynamics – STD lost days by selected impairments
Age influences impairment duration and time away from work



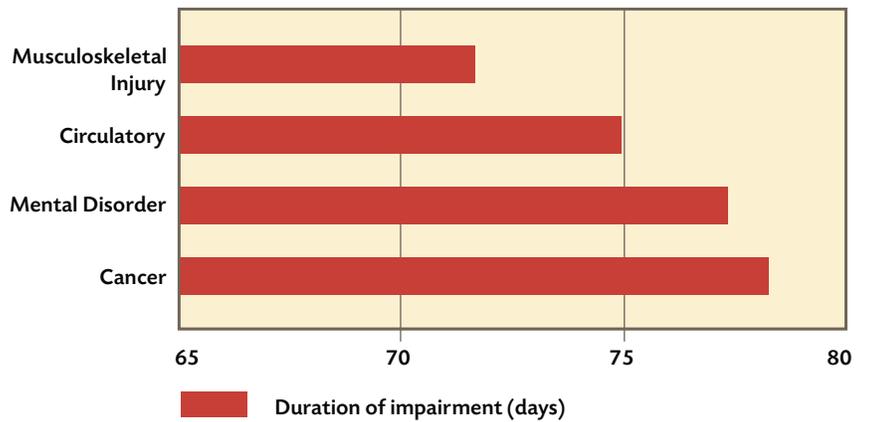
Source: UnumProvident Disability Database, 2002-2004.

Figure 2.9

The average time off work for the top four impairments for the worker over the age of 40 include musculoskeletal, circulatory, mental and cancer disorders.

While these four impairments are relatively close together in regard to average days away from work (only six days difference), cancer and mental health disorders (e.g. depression) are most likely to move the senior worker closest to crossing the threshold of long term disability. While these are very different types of impairments, their impact on work productivity are very similar. Both can have extended periods of eroding work disruption prior to diagnosis, with an ongoing impact on work capacity characterized by cycles of good and bad performance. Correspondingly, the ability to resume full levels of work may be affected by both a fear of returning to work and corporate policies.

Fig. 2.9 – Risk dynamics – top four STD impairments with the longest durations of time away from work for workers over 40

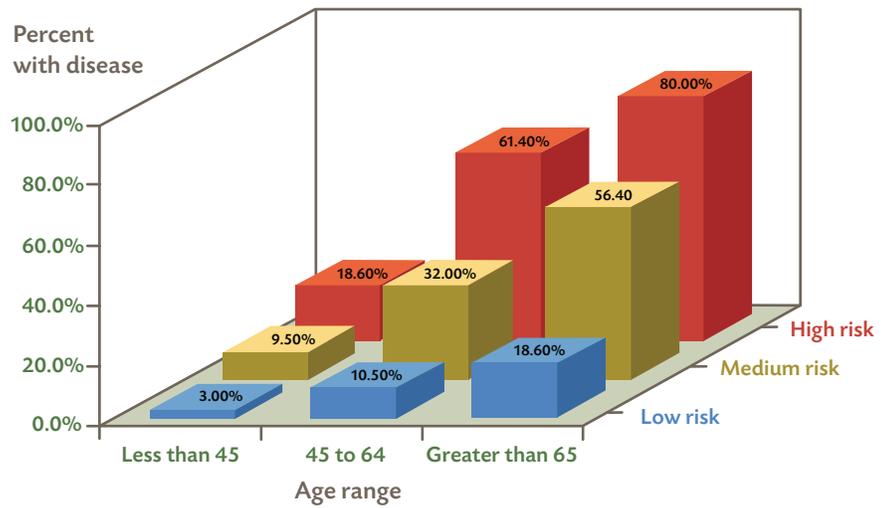


Source: UnumProvident Disability Database, 2002-2004.

Figure 2.10

The incidence of self-reported major diseases increases with age and specific risk factors. Those individuals with low risk factors (e.g. absence of obesity, smoking, sedentary lifestyle, high blood pressure) reported disease in 3% of the under 45 bracket, and 10.5% from age 45 to 64. Those under age 45 with medium risk reported 9.5% and those aged 45 to 64 reported 32%. This data considers high risk individuals to be those with four or more risk factors. In this bracket, 18.6% of those below age 45 self-reported a chronic disease and 61% between 45 and 64 reported a chronic disease. This data shows that while age is a factor in self-reporting, the presence of specific risk factors is an even greater one. Changing risk factors can play a critical role in remaining disease free and functionally capable.

Fig. 2.10 – Self-reported major diseases associated with excess risk



Source: Musich, McDonald, Hirschland, Edington. Disease Management & Health Outcomes 2002; 10(4): 251-258; University of Michigan Health Management Research Center.

Used with permission. Dee Edington, Ph.D. University of Michigan, Ann Arbor, Michigan

Figure 2.11

Healthcare costs rise as a person ages. Yet the driver of excessive healthcare cost by age is a result of the relative health risk the person has, not the age itself. Health risk factors such as smoking, obesity, uncontrolled blood pressure, etc. double and triple the healthcare cost of the older worker. For example, the health cost differential between the low-risk 40 and 50 year old and to the high-risk 40 and 50 year old is 3.0 and 2.8 times higher respectively. The health costs for the 60 year old with low risk is an estimated 2.4 times lower than the health risk for the high-risk 60 year old.

Fig. 2.11 – Healthcare costs by age x risk



Source: Musich, McDonald, Hirschland, Edington. Disease Management & Health Outcomes 2002; 10(4): 251-258; University of Michigan Health Management Research Center.

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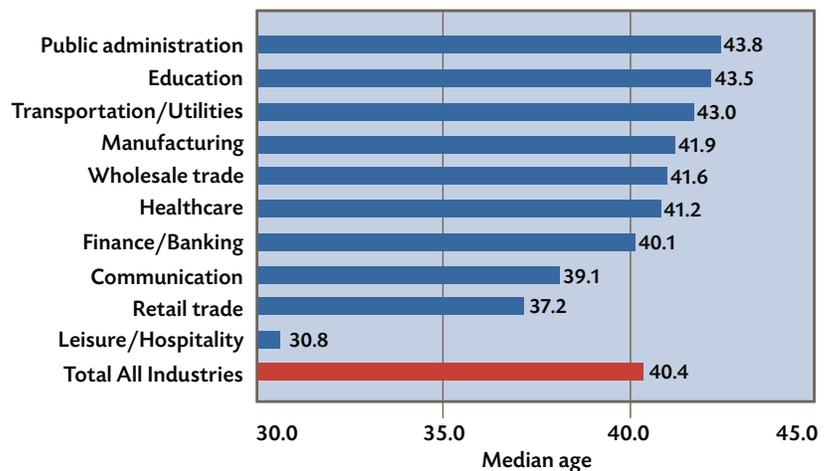
Productivity and lost time management strategies

*"I can't get old: I'm working.
As long as you're working,
you stay young."*

George Burns
(1896 -1996)

The development of strategies to protect and enhance productivity in the over 40 work force begins by recognizing the need and opportunities within specific industries. Figure 3.1 indicates that Public Administration and Education employers lead with the highest average employee age. Both groups represent an impending healthcare and productivity crisis for public-funded employers. In the U.S. private sector, transportation and utilities, wholesale trade, healthcare and finance/banking show the greatest opportunity to be affected by the 40+ year old worker.

Fig. 3.1 – Median age of employed population by selected industry



Source: 2003 Current Population Survey, U.S. Department of Labor

Health and productivity are connected. The corporate work-health culture is the link. The key connections are:

Productivity

- retention of the intellectual capital/skills of the older workers, especially through mergers and acquisitions
- increased demand for flexible work sites, work tasks and work schedules
- filling the post-age wave personnel gap with an emerging pool of workers aged 60+.

Health

- healthy aging through the assumption of a lifestyle that reduces risk and enhances functional capacity
- healthcare costs for employees, dependents and retirees
- increased risk factors by age, weight and chronic disease
- impact on family economic stability

Figure 3.2

The increased morbidity rate for the older worker also has a direct bearing on any strategies an employer may be undertaking to promote a healthier work force, reduce healthcare expenses and minimize productivity losses.

Older employees are at greater risk for experiencing low back pain, heart disease, diabetes, and obesity; diseases which have been reported in recent surveys as the costliest medical conditions for employers that are preventable.

Post-retirement healthcare benefit options – or the lack thereof – can be a major dilemma for many workers in their late 50s and early 60s who are considering retirement. This becomes a health benefit predicament when functional capacity begins to erode due to a chronic health problem impacting the ability to continue to work.

Corporate Work – Health Culture

- changes in expectations and definitions of benefit programs and retirement plans.
- employees are living longer, more actively creating expectations and the need for continued work
- intergenerational transfer of organizational memory

Fig. 3.2 – Benefit plan options

PROGRAM	FEATURES
Retirement programs and benefits	<ul style="list-style-type: none"> • Create benefit plan designs that promote phased-in retirements (for example, a retirement plan may use the top 5 years of earnings rather than the last 5 years of earnings for defined benefit formulas). • Work within regulatory guidelines (and help promote changing guidelines) to encourage flexible retirement
Wellness and disease management programs	<ul style="list-style-type: none"> • Expand exercise programs targeted for arthritis • Target educational programs on preventive strategies and on applied interventions that can reduce or minimize the impact of disease on productivity
Work life programs	<ul style="list-style-type: none"> • Implement flexible scheduling and job sharing opportunities for older employees as either a component of a phased-in retirement or as part of the work force planning strategy to retain needed workers
Job modifications	<ul style="list-style-type: none"> • Develop productivity pathways for common impairments experienced by older workers, thereby promoting the safe and timely resumption of work activities • Create career pathways which support transitions from more physically demanding roles to less demanding ones for older employees
Corporate culture	<ul style="list-style-type: none"> • Promote a culture that respects and utilizes experience • Include opportunities for older employee training to enhance skills and learn new ones

Corporate case study on productive aging

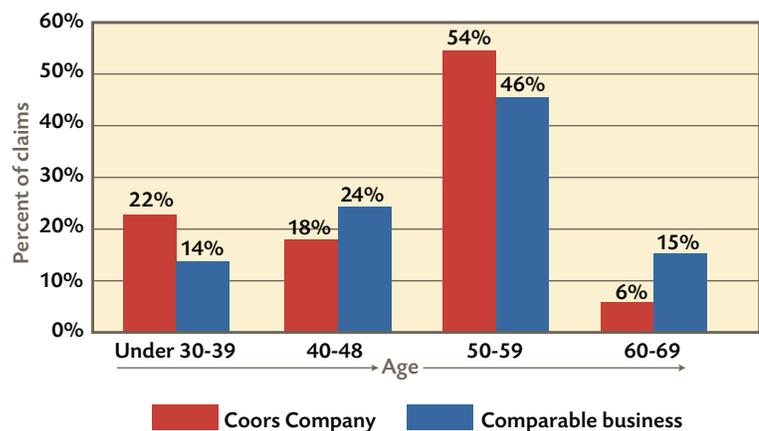


Happy, healthy and productive: This corporate theme guides day-to-day decisions at **Coors Brewing Company**, based in Golden, Colorado. For more than 100 years, the corporate culture has focused on the wellness of its 5,000 employees worldwide. The company's broad-based health and productivity program has been shown to have a measurable impact on its senior work force.

The challenge

With its average work force age 42, and the average hourly work force age 46, Coors has needed a flexible worksite that allowed for timely and time-specific work transitions, accommodating temporary and not-so-temporary impairments. Seventy five percent of the company's long term disability claims come from employees more than 40 years old. Most of those claims (54%) are musculoskeletal in nature.

Fig. 4.1 – Distribution of LTD claims by age



Source: UnumProvident Disability Database, 2002-2004.

The solution

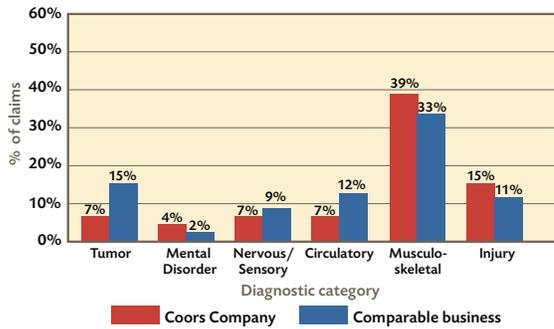
Coors has a long history of creativity, accountability and self-sufficiency, traits that are infused in the work force and reinforced in benefit programs. Although Coors programs do not specifically focus on the older worker, they effectively deal with many of the problems related to the aging workforce. The Coors employee has access to a full range of health and productivity resources, with incentives for their use:

- Health Risk Appraisal (HRA) with a \$200 premium-reduction incentive and 70% participation.
- 25,000 sq. ft. wellness center (the first corporate wellness center in the U.S.) free to employees and retirees.
- a variety of fitness programs.
- on-site physical therapy and medical center with reduced co-payments or free care and a \$10 co-pay for lab tests.

A critical part of the Coors health and productivity program is the Coors Health Coach, the employee health advocate who contacts employees found to be at risk by the HRA and directs them to the “next step” to reduce identified risk factors.

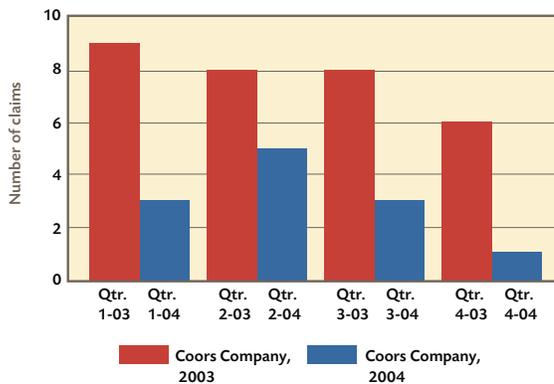
Corporate case study on productive aging

Fig. 4.2 – Distribution of LTD claims by diagnostic category



Source: UnumProvident Disability Database, 2002-2004.

Fig. 4.3 – LTD claim incidence – Quarterly Comparison



Source: UnumProvident Disability Database, 2002-2004.

The results

Coors Transitional Work Program, which was modified recently to cover all lost time events, offers a well-defined set of corporate-wide accommodations to assist the employee, management and attending physician in aligning the employee’s work capacity to job demands. This creates both stay-at-work and return-to-work options. The timely medical care, health coaches and transitional work add up to a measurable pattern of success in lost time management.

Two key patterns highlight the Coors long term disability profile:

- fewer claims are submitted (a 66% decrease between 2003 and 2004)
- a high percentage of LTD employees are returning to work during the first year

Summary

Coor’s goal of “winning in the beer business” starts with a continuous effort to protect the health and well being of its workforce. Through proactive measures to assess health risk early, incentives that encourage participation in preventive health measures, and flexible plans to return employees to work efficiently and quickly, it ensures a work force ready to meet that challenge.

Building a corporate culture that supports healthy aging

*“Age is an issue
of mind over matter.
If you don’t mind,
it doesn’t matter.”*

Mark Twain
(1835-1910)

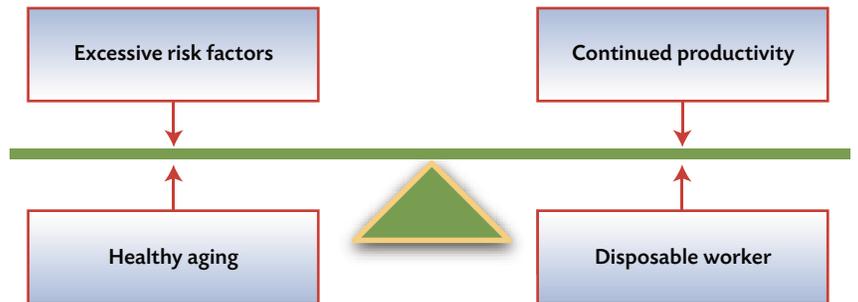
Productive aging is dependent on healthy aging. The paradox for employers and employees alike is striking the correct balance among:

- corporate productivity needs
- the corporate policies regarding the older worker
- the older worker’s desire and motivation for continued, sustained productivity
- the worker’s health and functional capacity

The key to solving the productive aging paradox is embedded in the design and development of a corporate culture that promotes and protects the productivity of its senior workers. This initiative can pay dividends both in healthcare cost reduction, as well as maintaining appropriate skills within the workplace. The dividend extends into the subsequent transitions to retirement.

Finally, there are many opportunities and a potentially measurable return on investment for employers to benefit from the experience and skills of the older worker. A critical step for the employer is to balance job demands and worker capacity with the productivity needs of the organization. The older employee’s health and functional well-being become the pivot point of success.

Fig. 5.1 – Competing pressures of the productive aging paradox



Where and how to begin? The key tasks that establish the connection between health and productivity for the senior work force are as follows. These can be applied sequentially or concurrently.

The productivity/aging operations connections

- create a corporate work-health culture that invests in productive aging
- understand and track predictors and costs of all forms of work disruption
- protect, enhance and reinforce current functional work capacity
- reduce employee health risk factors related to chronic disease through health risk appraisal screenings and incentives to change
- create focused pathways to maintain or return to full productivity based on a well defined stay at work and return to productivity prescriptions citing treatment programs that reduce restrictions and limitations created by the impairment(s)
- build flexibility and adaptability into work site, work style, work options, and work locations
- align training/education strategies to acquire new or maintain skills in the senior work force
- create opportunities for intergenerational mentoring/coaching with transfer of skills and information
- create incentives for phased career to retirement transitions

Figure 5.2

Providing incentives can encourage employees to stay healthy, reduce risk and maintain productivity. The management team looks for incentives to invest, develop and participate in such programs. Figure 5.2 offers a simple return on investment (ROI) illustration.

Health and lost time are connected. The ability of a management team to invest targeted resources to change both employee and management behavior pays off. This is called the health and productivity (H&P) dividend.

The H&P Dividend is real and measurable but requires the tangible investment in time and resources, and is powered by collaboration between the organization and its partners.

Fig. 5.2 – Health and productivity dividend

[Industry = Manufacturing; EE's = 2500 Avg Age = 42]	Base	
Manufacturer – Annual Sales	\$1,200,000,000	<p>ROI = 8:1</p> <ul style="list-style-type: none"> Reduce Turnover Delay retirement Work force diversity Knowledge retention
Operating earnings	\$144,000,000	
Operating margin	12.0%	
Estimated direct & indirect cost of lost time	\$2,100,000	
Program investment	\$100,000	
Productive aging estimated reduction in lost time costs 20%	\$700,000	
Estimated health care cost savings	\$500,000	

- 2,500 employee manufacturing employer
- average salary = \$40K
- assume 20% improvement in experience (incidence and duration of STD only)

Additional Resources

*“How old would you be if you
didn’t know how old you were?
You can be about as old
as you choose to be.”*

Leroy “Satchel” Paige
Baseball Hall of Fame
(est. 1906 -1982)

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*“Getting older is no problem.
You just have to
live long enough.”*

Groucho Marx
(1890 - 1977)

Health cost and lost time information used for this publication was generated, unless otherwise referenced, from UnumProvident’s disability database – the largest private disability database in the nation.¹ UnumProvident regularly applies the information within this database, which tracks 26.8 million lives and an estimated 178,000 employer policyholders, as an absence management tool.

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- Tamara Erickson, EVP, The Concours Group
- Christine Sheedy and Patricia Chambers, Osram Sylvania

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UnumProvident Corporation is the largest provider of group and individual income protection insurance in the United States and the United Kingdom.² With primary offices in Chattanooga, TN; Portland, ME; Worcester, MA; and Dorking England, the company employs nearly 13,000 people worldwide.

¹ UnumProvident represents the multiple insuring subsidiaries of UnumProvident Corporation, including the #1 group and individual income protection carriers in the United States, according to the JHA 2004 U.S. Group Disability Market Survey, 2005 and JHA 2004 U.S. Individual Disability Market Survey, 2005.

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