Application To: **BOSTON MUTUAL LIFE INSURANCE COMPANY**
Individual Life Insurance *(Endowment at age 95)*

120 Royall Street
Canton, MA 02021

PART A

Schedule of Proposed Benefits *(Employee/Owner)*

1. Proposed Insured *(Employee/Owner)* | 2. Gender ❑M ❑F

3. Date of Birth | 4. Age at Issue Date | 5. Social Security # / ITIN# | 6. Telephone #

7. Present Residence *(Required) - include apt. #, Street #, City, State, Zip*

PO Box/Communication Address *(Optional)*

8. Occupation *(Optional)* | 9. Are you actively at work? ❑Yes ❑No

10. Employer | 11. Date of Employment

12. Amount of Insurance $ | 13. ❑Weekly, ❑Bi-Weekly, ❑Monthly or ❑Semi-Monthly Premium $_____

14. Automatic Premium Loan on all Policies? ❑Yes ❑No

15. Additional Benefits:	Amount	Premium
❑ Waiver of Premium	$	$
❑ Accidental Death Benefit	$	$
❑ Children's Insurance Benefit	$	$
❑ Level Term to age 65	$	$
❑ Other _____	$	$

16. Beneficiary for Primary & Contingent - ***Name, Relationship,*** *Address, Telephone #, SS #, D.O.B. (Beneficiary will be employee's estate if left blank)*

Primary:

Contingent:

Schedule of Proposed Benefits *(Spouse)*

17. Proposed Insured *(Spouse)* | 18. Gender ❑M ❑F

19. Date of Birth | 20. Age at Issue Date | 21. Telephone #

22. Present Residence *(St. address)* Same address as employee? ❑Yes ❑No
If NO, provide reason/details in Remarks #30

23. Are you actively at work? ❑Yes ❑No
If NO, provide reason/details in Remarks #30

24. Amount of Insurance $ | 25. ❑Weekly, ❑Bi-Weekly, ❑Monthly or ❑Semi-Monthly Premium $_____

26. Additional Benefits:	Amount	Premium
❑ Payor Waiver of Premium	$	$
❑ Accidental Death Benefit	$	$
❑ Children's Insurance Benefit	$	$
❑ Level Term to age 65	$	$
❑ Other _____	$	$

27. Total Employee Premium $ _____
Total Spouse Premium $ _____
Total Children Premium $ _____
Total Premium $ _____

28. Beneficiary for Primary & Contingent - ***Name, Relationship,*** *Address, Telephone #, SS #, D.O.B. (Beneficiary will be employee's estate if left blank)*

Primary:

Contingent:

29. Have any of the proposed insureds used any tobacco or nicotine products in the past twelve months? *(only complete for smoker/non-smoker policy)* Employee ❑Yes ❑No Spouse ❑Yes ❑No

30. Remarks:

31. Children's Benefits: Employee is Beneficiary, if living, otherwise the employee's estate.

32. Proposed Additional Insured(s) *(children and/or grandchildren)* Name *(first & last)*	Date of Birth Mo Day Yr	Age	Gender M or F	Relationship to Applicant	For Permanent Insurance Only: Premium	Amt. of Ins	ADB Prem	PW Prem	Smoker 18+
									❑Yes ❑No
									❑Yes ❑No
									❑Yes ❑No
									❑Yes ❑No

33. Has the applicant any existing life insurance policies in force? ❑Yes ❑No *If Yes, please complete the Notice of Replacement.*

34. Will the policy applied for replace or change any life insurance or annuities in force on the life of any proposed covered person? If Yes, give the name of the company and policy # being replaced, and enclose any required state replacement forms. ❑Yes ❑No

Company Name _____ Policy # _____

PART B To be completed for any proposed insured *(employee, spouse, children and/or grandchildren)* who is applying for more than the Guaranteed Issue limit. An additional sheet of paper may be attached if needed.

35. Name of Proposed Insured	Relationship to Employee	Height	Weight
		ft. in.	lbs.
		ft. in.	lbs.
		ft. in.	lbs.

36. In the past 5 years have any of the proposed insureds been diagnosed by a member of the medical profession with:

A. (1) asthma, emphysema or COPD *(chronic obstructive pulmonary disease or disorder)*; (2) high blood pressure, stroke, heart or circulatory disease or disorder; (3) intestinal disease or disorder or ulcer; (4) leukemia, cancer, tumor or malignancy; (5) epilepsy, mental or nervous disease or disorder; (6) kidney or genito-urinary disease or disorder; (7) liver disease; (8) pancreatitis *(new or acute)*; (9) thyroid disorder; (10) transient ischemic attack *(TIA)* or (11) disorder of the back, muscles, bones or joints? ❑ Yes ❑ No

B. (1) diabetes requiring insulin, been prescribed or used insulin for the treatment of diabetes, or been diagnosed with or treated for complications of diabetes, including Insulin Shock, Diabetic Coma, Retinopathy, Neuropathy, Amputation, Nephropathy, Kidney disorder or End stage renal disease? ❑ Yes ❑ No

C. (1) having Amyotrophic Lateral Sclerosis (ALS)? ❑ Yes ❑ No

D. (1) having Huntington's chorea? ❑ Yes ❑ No

E. (1) having Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome *(AIDS)*? ❑ Yes ❑ No

37. In the past 5 years have any of the proposed insureds (1) been hospitalized or had hospitalization recommended; (2) had a physical examination or medical test with other than normal results? ❑ Yes ❑ No

38. In the past 5 years have any of the proposed insureds used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, opioids or other habit forming drugs, except as prescribed by a member of the medical profession? ❑ Yes ❑ No

39. In the past 5 years have any of the proposed insureds received medical treatment or counseling for, or been advised by a member of the medical profession to discontinue, the use of alcohol or prescribed or non-prescribed drugs? ❑ Yes ❑ No

40. Do any of the proposed insureds: (1) fly, or intend to fly, within the next 2 years, as a pilot or crew member; (2) race or test any form of vehicle; (3) skin or scuba dive; (4) hang glide or sky dive? ❑ Yes ❑ No

41. Details for questions 36 through 40 answered "YES". Include question number. An additional sheet of paper may be attached if needed.

Name	Disease or Injury	Date Diagnosed	Details - *include treatment & medications*

AGREEMENT AND DECLARATION - Read Carefully Before Signing

I/WE represent that the statements and answers written in this application parts A & B and any supplements are complete and true to the best of my/our knowledge and belief, and it is agreed that:

A. This application and any supplement shall form the basis for and become a part of any policy issued.

B. The agent has no authority to waive the answer to any question in, or to modify, the application. No information will be considered to have been given to the company unless it is stated in the application, and that they will notify the company of any change in the statements or answers given between the time of the application and delivery of the policy.

C. The insurance applied for shall be in force as of the date of this application signed by me, provided that the Company approved the application without any modification as to plan, amount of premium, and, further provided that the Company receives the first premium payment from my employer within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance will become effective. If the application is approved with any such modification, the insurance shall not take effect until the policy has been delivered to and accepted by me.

D. The employee will be the owner unless otherwise stated in Remarks #30. In the event of the employee's death, ownership will transfer to the primary beneficiary unless a contingent owner is designated.

E. I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. Upon request, I may be informed as to whether a consumer report was requested, and if such report was requested, I will be informed of the name and address of the consumer reporting agency that furnished the report. If the use of a consumer report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual Life Insurance Company of my rights, under the FCRA concerning that action.

F. I acknowledge that I have received a copy of Boston Mutual Life Insurance Company's Notice of Privacy Practices.

G. FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Employee *(Owner)* _____ Signature of Spouse *(If required by State law)* _____

Signature of Dependent Children *(If required by State law)* _____

Agent's statement: To the best of your knowledge, does this insurance replace or change any existing insurance or annuities? ❑ Yes ❑ No

Witnessed *(Licensed Agent)* _____ Signed state _____ Date ____/____/____

Print Licensed Agent Name _____ NPN # _____

You have the right to designate a third party for your policy. If designated, the policy owner and the designated third party will be notified of possible cancellation of the policy. I hereby designate the following person as a third party:

Name, Address and Telephone # of Third Party: _____

Important Notice: Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement. You should carefully consider whether a replacement is in your best interest. You will pay acquisitions costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO

If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing *(include the name of the insurer, the insured, and the contract number if available)* and whether each policy will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.				

Make sure you know the facts. Contact your existing company or its agents for information about the old policy or contract. *(If you request one, an in-force illustration, policy summary, or available disclosure documents must be sent to you by the existing insurer.)* Ask for and retain all sales materials used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

_____

_____

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant’s Signature	Printed Name	Date
Producer’s Signature	Printed Name	Date

I do not want this notice read aloud to me. _____ *(Applicants must initial only if they do not want the notice read aloud.)*

Replacement of Life Insurance or Annuities...*cont.*

A replacement may not be in your best interest, or your decision could be a good one.You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract.One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense.

PREMIUMS:

Are they affordable?

Could they change?

You're older - are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.
(Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.)

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST-SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? *(See your tax advisor.)*

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formally known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

MIB REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

BOSTON MUTUAL LIFE INSURANCE COMPANY
AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION
(This authorization complies with the HIPAA Privacy Rule)

I authorize any health plan, insurer, physician, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, services, or payment to the Proposed Insured/s, or on their behalf, as well as the MIB, Inc. *(formally known as the Medical Information Bureau, Inc.)* and other medical information providers, to disclose the entire medical record and any other Protected Health Information concerning such person to the Boston Mutual Life Insurance Company (BML), its employees and representatives. This authorization specifically includes the release of all information related to my health or that of my minor children and or my minor children's insurance policies and claims, including but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco, but excludes psychotherapy notes. The Protected Health Information is being disclosed so that BML may: 1) underwrite/assess an applicant's eligibility for coverage, 2) obtain reinsurance, 3) pay claims and, 4) conduct other legally permissible activities related to the coverage applied for by this individual. The time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. A copy of this authorization is as valid as the original. I understand that: I or my authorized representative have the right to revoke this authorization at any time by sending a written request for revocation. Revoking or failing to sign this Authorization may impair BML's ability to process this application; a revocation is not effective to the extent that the Authorization has been relied on for the above listed uses; any information disclosed pursuant to this authorization may be redisclosed and redisclosed information may no longer be covered by federal rules governing privacy or health information. I acknowledge that I have received a copy of BML's Notice of Privacy Practices. I have read this Authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Primary Proposed Insured _____ Date _____