Application To

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 Royall Street
Canton, MA 02021

PART A Schedule of Proposed Benefits *(Employee/Owner)* — Schedule of Proposed Benefits *(Spouse)*

1. Proposed Insured *(Employee/Owner)*			2. Gender ☐ M ☐ F
3. Date of Birth	4. Age	5. Place of Birth State	6. Home Phone No. ( )
7. Present Residence *(show P.O. Box mailing address in special requests)* No. Street City State Zip			
8. S.S. No. *(Employee)*	9. Are you actively at work? ☐ YES ☐ NO		
10. Amount of Insurance $	11. Weekly Premium $		

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

13. Beneficiary -
Primary: _____ Relationship _____ Age _____
Contingent: _____ Relationship _____ Age _____

14. Employer	Date of Employment	Employee No.

15. Proposed Insured *(Spouse)*			16. Gender ☐ M ☐ F
17. Date of Birth	18. Age	19. Place of Birth State	
20. Present Residence *(same as employee ☐ YES ☐ NO)* If NO, provide details in Special Request			
21. During the past six months, has your spouse been seen or treated, including testing, in a hospital or any other medical facility, excluding physicians' offices for routine medical care? *(If yes, complete questions in Part B.)* ☐ YES ☐ NO			
22. Amount of Insurance $	23. Weekly Premium $		

24. Additional Benefits:	Amount	Premium
☐ Payor Waiver		$
☐ Accidental Death Benefit	$	$
☐ Children's Insurance Benefit	$	$
☐ Level Term to age 65	$	$
☐ Other	$	$

25. Total Employee Weekly Premium $ _____
Total Spouse Weekly Premium $ _____
Total Children Weekly Premium $ _____
Total Weekly Premium $ _____

26. Beneficiary -
Primary: _____ Relationship _____ Age _____
Contingent: _____ Relationship _____ Age _____

27. Automatic Premium Loan on all policies included on this application? ☐ YES ☐ NO

28. Have any of the proposed insureds used any tobacco or nicotine products in the past two years? *(only complete for smoker/non-smoker policy)*
Employee ☐ YES ☐ NO; Spouse ☐ YES ☐ NO; Children *(over age 18 only)* ☐ YES ☐ NO

29. Schedule of Proposed Benefits *(Children)* The Children's Beneficiary will automatically be the employee, if living, otherwise the spouse named in the application. If another beneficiary is preferred please indicate in special request.

Name *(first)* *(last)*	Date of Birth Mo.	Day	Yr.	Age	Gender M or F	Relationship to Applicant	For Permanent Insurance Only: Wkly Prem	Amt. of Ins.	ADB Prem.	PW Prem.	Smoker
											☐ Yes ☐ No
											☐ Yes ☐ No
											☐ Yes ☐ No
											☐ Yes ☐ No

30. Has the applicant any existing life insurance policies in force? ☐ YES ☐ NO *If YES, please complete the Notice of Replacement on this form.*

31. Will the policy applied for replace or change any insurance or annuities in force on the life of any proposed covered person? If yes, give the name of the company and policy no. being replaced, and enclose any required state replacement forms. ☐ YES ☐ NO
Company Name _____ Policy Number _____

32. Special Requests:

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.

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 or 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 take effect upon approval of the application and provided that there has not been a change in the health, as stated in the application, of any person to be insured. I authorize my employer to deduct for this insurance.

D. The employee will be the owner unless otherwise stated. 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 to obtain a consumer social security number report and/or a consumer credit report on me. I understand that information supplied by me on the application may be verified through one or both of these reports and information which cannot be verified through this process, as correct, will be used in whole or in part to determine my eligibility for insurance coverage.

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

G. CAUTION: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Employee *(Owner)*

Signature of Spouse *(If required by State law)*

Signature of Dependent Children age 18 and over *(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 at _____ this _____ day of _____ (yr) _____

Print Licensed Agent Name NPN #

PART B 33. To be completed for any proposed insured who is applying for simplified issue.

Name of Proposed Insured	Relationship to Employee	Height	Weight

34. In the past 10 years, have any of the proposed insureds ever been told by a licensed member of the medical profession that they had:

A. (1) asthma or emphysema; (2) high blood pressure, stroke, heart or circulatory disease or disorder; (3) intestinal disease or disorder or ulcer; (4) diabetes; (5) leukemia, cancer, tumor or malignancy; (6) epilepsy, mental or nervous disease or disorder; (7) kidney or genito-urinary disease or disorder; or (8) disorder of the back, muscles, bones or joints? ☐ *Yes* ☐ *No*

B. Have any of the proposed insureds been treated for or been diagnosed by a licensed member of the medical profession as having an immune deficiency disorder or AIDS *(Acquired Immune Deficiency Syndrome)*? ☐ *Yes* ☐ *No*

C. In the past 5 years, have any of the proposed insureds; (1) been hospitalized or had hospitalization recommended by a member of the medical profession; (2) had a physical examination or medical test with other than normal results? ☐ *Yes* ☐ *No*

D. Do you or your spouse: (1) fly, or intend to fly, as a pilot or crew member; (2) race or test any form of vehicle; (3) scuba dive; (4) hang glide or sky dive? ☐ *Yes* ☐ *No*

E. Has any proposed insured used on a regular basis or are they currently using or ever received treatment or consultation for the use of heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs or alcoholism? ☐ *Yes* ☐ *No*

35. Details for questions A, B, C, D, E, answered "Yes".

Name	Disease or Injury	Date	Details

• NOTICE OF REPLACEMENT OF LIFE INSURANCE OR ANNUITIES •

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 interests. You will pay acquisition 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 or contract 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.

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

Please 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)**

Make sure you know the facts. Contact your existing company or its agent 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 material 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:

Employee's Signature and Printed Name | Producer's Signature and 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.)*