

**EVIDENCE OF INSURABILITY & APPLICATION FOR INSURANCE TO:**

Refer to the Group Policy for types of coverage available & eligible amounts of insurance

**Boston Mutual Life Insurance Company**  
 Attn: Group Administration Department  
 120 ROYALL STREET, CANTON, MA 02021-9968

**Application Required For Each Employee**

**TO BE COMPLETED BY POLICYHOLDER**

GROUP NUMBER		DIVISION NUMBER		EMPLOYER/GROUP NAME	
EMPLOYEE/MEMBER (FIRST, MIDDLE INITIAL, LAST)					
SOCIAL SECURITY NUMBER					
HOME ADDRESS		HOME TEL.		HOME TEL.	
DATE OF HIRE	DATE OF BIRTH	CLASS	SEX (M or F)	OCCUPATION OR JOB TITLE	# HRS WORKED WEEKLY
<input type="checkbox"/> LIFE <input type="checkbox"/> AD&D		<input type="checkbox"/> Long Term Disability    \$ _____		Monthly Benefit	
Current Coverage Under Plan: \$ _____		<input type="checkbox"/> Weekly Disability Income    \$ _____		Weekly Benefit	
Coverage Being Applied For: \$ _____		<input type="checkbox"/> Excess Loss    \$ _____		Individual Deductible	
Total Proposed Coverage Under Plan: \$ _____		<input type="checkbox"/> Late Applicant <input type="checkbox"/> Applying for Supplemental Coverage <input type="checkbox"/> Other			
<input type="checkbox"/> Adding Dependent Child <input type="checkbox"/> Applying for Coverage in excess of Guaranteed Amount					
<input type="checkbox"/> Adding Spouse					

**TO BE COMPLETED BY INSURED**

Employee/Member     Employee & Dependents     Dependents only (employee already covered) (if you want Dependent coverage, list all your dependents below)

NAME	RELATIONSHIP	DATE OF BIRTH	HEIGHT	WEIGHT
Please list all life insurance now in force or pending on your life:				

Name of Company	Life Amount	AD&D Amount	Year Issued or Pending	Do you intend to cancel or change this coverage if you and your dependents are approved for the insurance applied for on this application?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you or your dependents currently, or have you or your dependents within the last two years participated in skin or scuba diving or flying as a pilot or crew member or organized auto or motorcycle racing? .....  YES     NO

If yes, please give details on reverse side in the details section.

GRP - EVID (12/94) CA

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**NOTICE OF INFORMATION PRACTICES (Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)**

**This Notice Must Be Given To Proposed Insured**

In considering your application, information from various sources will be considered. These include your statements, the results of your physical examination (if required), and reports we get from doctors or medical facilities which have attended you. Information about your insurability will be treated as confidential. We, or our reinsurers, may, however, make a brief report of this to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file (medical information will be disclosed only to your attending physician). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We, or our reinsurers, may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom a claim is submitted.

