BOSTON MUTUAL LIFE INSURANCE COMPANY

120 Royall Street • Canton, MA 02021 1-800-669-2668 Ext. 473

EVIDENCE OF INSURABILITY FORM FOR INSURANCE

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

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

PLEASE COMPLETE IN FULL

IMPORTANT
Submit with completed Enrollment form.

EMPLOYER SECTION

Group #	Div. #	Employer/Group Name
Social Security #		Employee Name *(Last, First, Middle Initial)*
Telephone #		Address

PROPOSED INSURED(S)

Name	Relationship	Date of Birth	Height	Weight

REASON

NEW

- ❑ Late Applicant
- ❑ Applying for Coverage in Excess of the Guaranteed Amount
- ❑ Applying for Supplemental Coverage
- ❑ Other _____

CHANGE

- ❑ Increase in Coverage
- ❑ Adding 2nd Insured
- ❑ Increasing 2nd Insured
- ❑ Adding Dependent Child(ren)
- ❑ Other _____

APPLYING FOR . . .

YOU	**LIFE**	**AD&D**	**VOLUNTARY LIFE**	**VOLUNTARY AD&D**
Current Insurance				
Additional Insurance Requested				
Total New Coverage				

- ❑ Short Term Disability $ _____ *Weekly Benefit*
- ❑ Long Term Disability $ _____ *Monthly Benefit*
- ❑ Other $ _____

SECOND INSURED	**LIFE**	**AD&D**	**VOLUNTARY LIFE**	**VOLUNTARY AD&D**
Current Insurance				
Additional Insurance Requested				
Total New Coverage				

- ❑ Other $ _____

EVIDENCE OF INSURABILITY

1A. Existing Coverage

Please list all life insurance and/or annuity contacts now in-force or pending on your life

Name of Company *(if replacement include Policy No.)*	Life Amount	AD&D Amount	Year Issued or Pending	Do you intend to replace or change this coverage if you and your dependents are approved for the insurance applied for on this application?
				❑ YES ❑ NO
				❑ YES ❑ NO

1B. To be Completed for ALL Proposed Insured(s) if Required by the Group Insurance Contract

Have you used any form of tobacco products (cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches) within the past 12 months? ** **Employee** ❑ YES ❑ NO **Second Insured** ❑ YES ❑ NO

** ***I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted to the amount which the premiums would have purchased if the questions had been answered correctly.***

2. Have ANY of the proposed insureds ever had or been told by a 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 physician as having AIDS? ❑ YES ❑ NO

C. 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? **(Excludes AIDS/HIV/ARC)** ❑ YES ❑ NO

D. Do you or your spouse: 1) fly, or intend to fly, as 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

3. Details for questions 2 - A, B, C, D, E answered "YES". Include question number.

Name	Disease or Injury	Date (s)	Details/Treatment	Names & Address of Attending Phy's & Hospitals

REPRESENTATIONS AND NOTICE TO APPLICANTS

I/we represent that the statements and answers in this Evidence of Insurability form are complete and true to the best of my/our knowledge and belief. I/we agree that this form shall form the basis for and become a part of the consideration for the insurance applied for.

I acknowledge that I have received a copy of BML's Notice of Information Privacy Practices.

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

Signature of Applicant *(Employee/Member)* | Date | Signed & Dated at *(City, State)*

Signature of Applicant *(Other than Employee/Member)* | Date | Signed & Dated at *(City, State)*
(Employee/Member if the proposed insured is under 15)

Thank you for considering Boston Mutual Life Insurance Company as your insurance carrier.
Your application will receive our immediate and full consideration.