BOSTON MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 120 Royall Street • Canton, MA 02021
TEL (877) 212-2950 FAX 781-770-0492

FAMILY MATTERS. NO MATTER WHAT.®

CATASTROPHIC LOSS/CHRONIC ILLNESS CLAIM KIT

INSTRUCTIONS FOR FILING A CATASTROPHIC LOSS/CHRONIC ILLNESS CLAIM

If you have the Catastrophic Loss/Chronic Illness Rider on your life insurance coverage, you may be eligible for a monthly benefit if, due to sickness or injury, you are continuously not able to perform two or more Activities of Daily Living without assistance. The Elimination Period and Benefit Amount will appear on your Policy Specification page if you have this Rider. No benefits are payable during the elimination period. Activities of Daily Living as defined in the Rider are Continence, Bathing, Transferring, Dressing, Toileting and Eating.

1. Please complete the Policyholder/Claimant's Information section. *(If additional space is needed to include all names of doctors or hospitals, please attach a separate piece of paper)*

2. Please read and sign the appropriate HIPAA compliant authorization. *(The authorization will help us obtain any additional medical information needed to complete the processing of your claim)* This can be found on our website at www.bostonmutual.com.

3. Please read and sign the enclosed Disclosure Statement.

4. Have your physician complete the Attending Physician's Statement.

5. Review the **"FRAUD WARNING NOTICES"** for your state.

6. If you wish to receive your proceeds via direct deposit to your banking account, please be sure to complete the enclosed EFT Authorization form and include it with your other claim paperwork when you send it in.

If you should need assistance in the completion of the claim form please call 877-212-2950
Mail forms to: Boston Mutual Life Insurance Company – 120 Royall Street • Canton, MA 02021
Or send forms via secure email to: claimsdept@bostonmutual.com
Or fax forms to: 781-770-0492

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POLICYHOLDER/CLAIMANT'S STATEMENT

Full Name of Insured: ______________________ Policy No: __________

Is Insured Known by any other name? ☐ YES ☐ NO If YES, please advise: __________

Date of Birth: __________ Social Security No. __________ Telephone No. __________

Address: ______________________
Street or PO Box *Apt. No.* *City/State* *Zip Code*

What is your primary diagnosis? ______________________

Date of Illness/Accident: __________ Date First Treated: __________

Please provide examples of what Activities of Daily Living you require assistance with:

____

____

____

Are there any other conditions contributing to your need for assistance? ☐ YES ☐ NO

If YES, please explain: ______________________

____

Where are you currently residing: ☐ Residence ☐ Hospital ☐ Residential Care Facility
☐ Nursing Care Facility *(Nursing Home)* ☐ Assisted Living Facility ☐ Other __________

Please list all treating Physicians/Hospitals for this injury or illness: Use separate sheet if necessary.

Name of Physician/Hospital	Address	Date(s) treated

CERTIFICATION – Any person who knowingly and with 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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to "Fraud Warning Notices" insert for your state.

X ______________________ __________
Signature of Insured Date

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ATTENDING PHYSICIAN'S STATEMENT

Note: Insured is Responsible for any cost involved in the completion of this Attending Physician's Statement

Patient Name: ______________________ Date of Birth: ______________

Diagnosis and Concurrent Conditions: ______________________

Date first treated for this condition: ______________ Date Last Treated: ______________

Has patient ever had same or similar condition: ☐ YES ☐ NO

If YES, please explain:

____

Activities of Daily Living – *Please indicate activities of daily living for which the patient requires assistance.*

- ☐ **Continence:** Maintaining control of bladder and/or functions of the bowel, including the ability to use ostomy supplies or other devices such as catheters.
- ☐ **Bathing:** Washing in a bathtub, shower, or other accepted manner, including getting in and out of the bathtub or shower.
- ☐ **Transferring:** Moving between the bed and the chair or the bed and a wheelchair with or without assistive device.
- ☐ **Dressing:** Putting on and taking off all necessary items of clothing and/or medically necessary braces and artificial limbs usually worn.
- ☐ **Toileting:** Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.
- ☐ **Eating:** Performing all major tasks of getting food into the body with or without assistive device.

What is your prognosis for recovery? ______________________

The patient's current level of impairment will remain the same for approximately:

☐ 3-6 months ☐ 6-12 months ☐ 1-2 years ☐ 2+ years

Is the patient mentally competent to understand ordinary business transactions and to receive proceeds of insurance? ☐ YES ☐ NO

After you have completed this form, please attach copies of office notes, test results, hospital admission and discharge summaries and any consulting physician's reports relating to the above medical condition.

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Date: ______________ Signature: ______________________

Physician's Full Name: ______________________ Telephone No: ______________

Address: ______________________

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AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Name: ______________________________ Policy No: ______________

Complete the information below to authorize Boston Mutual Life Insurance Company *("Boston Mutual")* to directly deposit your benefits into the bank account referenced below via Automated Clearing House (ACH) / Electronic Funds Transfer (EFT). A voided check or signed specification *(spec)* sheet / letter of instruction from the bank must be submitted with this form. Deposit slips and starter checks will not be accepted.

Bank Account Type: *(select one)* ❑ Checking Account ❑ Savings Account

Full Legal Name on Bank Account: ______________________________

Name of Bank / Financial Institution: ______________________________

Bank routing / ABA Transit # *(9 digits)*: ______________________________

Account #: ______________________________

This authority is to remain in full force and effect until Boston Mutual has received written notification from me of its termination in such time and in such manner as to afford Boston Mutual and the Bank/ Financial Institution a reasonable opportunity to act on it.

Disclosures

- Boston Mutual shall incur no liability as a result of a deposit being dishonored by your bank.
- If Boston Mutual cannot make a deposit into the designated bank account via ACH / EFT for any reason, we reserve the right to mail a check to the claimant/beneficiary at the address of record.
- ACH / EFT is only available for U.S.-based banks or participating credit unions.
- It may take up to 2-3 business days from the date the disbursement is processed for your bank to reflect the deposit.

I authorize Boston Mutual to deposit funds into the designated bank account through an ACH / EFT. I agree that if there is an overpayment on my claim, I will promptly refund the full amount of any such overpayment by check.

Date: ______________ Signature of Claimant/Beneficiary: ______________________________

Claim Services | ClaimsDept@bostonmutual.com

120 Royall Street • Canton, MA 02021 • T: 877.212.2950 F: 781.770.0492 • www.bostonmutual.com

NOTICE OF INFORMATION PRIVACY PRACTICES

FAMILY MATTERS. NO MATTER WHAT.®

Boston Mutual Life Insurance Company

(Herein referred to as "we", "us", "our")

PROTECTING YOUR INFORMATION

To protect your nonpublic personal information, we maintain: physical, electronic and procedural safeguards.

COLLECTING INFORMATION

We collect information about you in order to conduct business. Such uses are: to process requests for insurance products, to provide customer service, to process claims, to fulfill legal and regulatory requirements and for other lawful purposes. We collect this information from you, as well as from other sources. We restrict access to your information to those working on our behalf who have a need to know it in order for us to provide products and services to you. We require them to secure the information and keep it confidential.

- ***Information we collect may include all the information you share with us including, for example, your:***
  - name
  - address
  - telephone number
  - date of birth
  - social security or tax identification number
  - employer name and income
  - beneficiary data
  - financial account numbers
  - medical information
  - and other information you share with us
- ***We may also collect data we receive from other sources, as allowed by law, which may include:***
  - medical information
  - consumer report information in accordance with the Fair Credit Reporting Act
  - participant information from organizations that purchase products or services from us for the benefit of their members or employees, such as group insurance
  - information to assist us in complying with state and federal laws

SHARING INFORMATION

We do not share information about our customers or former customers with anyone, except as permitted or required by law.

- ***We may share your information with third parties without your authorization as permitted by law. Such information is used on our behalf by these third parties to:***
  - process or service your insurance transactions with us
  - perform underwriting, administrative, account maintenance and claims functions
  - provide customer service or reinsurance coverage
  - prevent fraud
  - perform other business functions on our behalf
- ***We may also share your information with:***
  - a consumer reporting agency in accordance with the Fair Credit Reporting Act
  - a third party to comply with federal, state or local laws, subpoenas, or summonses
  - regulators
  - or as otherwise permitted or required by law.

Third parties receiving information from us are required to: keep it confidential and to comply with all applicable federal and state privacy laws.

ACCESS TO YOUR INFORMATION WE HAVE IN OUR RECORDS

You have the right to request access to all the information we have on you. You must make your request in writing at the address below.

AMENDMENTS TO YOUR INFORMATION

You have the right to request an amendment, correction or deletion of information which we hold about you which you believe may be inaccurate. We are not obligated to make updates to your data based on your request. You must make the request in writing and state the reasons you are requesting the change. Write us at the address below.

If you have questions about this notice or would like more information about our privacy policies, please write us at:

Boston Mutual Life Insurance Company
Attention: Privacy Office
120 Royall Street • Canton, MA 02021

FRAUD WARNING NOTICES – For Use with Claim Forms
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH Rev. Stat. Ann. §638:20.

see other side

FRAUD WARNING NOTICES – For Use with Claim Forms *(cont.)*

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

PENNSYLVANIA: Any person who knowingly and with 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.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED THE STATE LAW.

WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALL OTHER STATES: Any person who knowingly and with 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.