BOSTON MUTUAL LIFE INSURANCE COMPANY

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

EVIDENCE OF INSURABILITY FORM FOR GROUP 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 Spouse
- ☐ Increasing Spouse
- ☐ 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 $ _____

YOUR SPOUSE	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 **Spouse** ❑ 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** *I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted to the amount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 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; 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 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.

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.

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.

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 ROYALL STREET • CANTON, MASSACHUSETTS 02021 • 800-669-2668

Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY

(This authorization complies with the HIPAA Privacy Rule)

Name of *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

Name of Second *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *("Providers")* that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes**. I also authorize MIB, Inc. *(formerly known as the Medical Information Bureau, Inc.)*, to provide protected health information.

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization**, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that **I have the right to revoke this authorization in writing**, at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments**. I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient _____

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient _____

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____, the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured _____ Date _____