The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

NOTICE TO PRODUCER

Please complete the application properly and ensure that you have satisfied all of our requirements. Please follow these instructions carefully. All forms must be completed in full and must be legible. We sincerely appreciate your business.

DO

- Give the Notice to Proposed Insured and/or Owner before completing the application.
- Print in black ink.
- Obtain all necessary signatures.
- Ask all questions and fully and accurately record all answers given – the application will be a part of any policy issued.
- Promptly schedule any required exams.
- Obtain proper identification and sufficient information about the customer and source of funds to ensure that you have verified the customer's identity and money laundering is not involved in the transaction.
- Have the Applicant initial any and all changes. In addition, the Proposed Insured must initial all changes to questions involving insurability.
- If you accept payment with the application:
  - Complete the Conditional Receipt Agreement (CRA) if applicable.
  - For payment by check obtain a currently dated check made payable to: The Savings Bank Mutual Life Insurance Company of Massachusetts. For Automatic Payment Plan (APP) cases, two (2) months premium must be collected in order to give a CRA. The completed APP Form and voided check should accompany the application.
  - For payment by credit card complete the Authorization for Payment of Initial Premium by Credit Card Form.
  - Explain the terms and conditions of the CRA to the Owner and the Proposed Insured and have them sign it.
  - Complete and sign the Agent/Broker section on the CRA.
  - Give the Owner the COPY of the CRA. Keep the ORIGINAL with the application.
  - Promptly send the payment and the Application – Part I, including the ORIGINAL CRA to The Company.

DO NOT

- DO NOT use pencil or correction fluid.
- DO NOT attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify the contract.
- DO NOT promise or imply that we will provide insurance.
- DO NOT accept payment in the form of cash/currency or Traveler's Check.
- DO NOT accept a check made payable to you or with the payee left blank.
- DO NOT accept payment if the Proposed Insured's age nearest birthday exceeds 70 years or is under 15 days.
- DO NOT offer the CRA if the Proposed Insured is not a Standard class or better.

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4046, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

NOTICE TO PROPOSED INSURED AND OWNER (This must be given to the Proposed Insured and Owner)

Thank you for considering The Savings Bank Mutual Life Insurance Company of Massachusetts (SBLI), (referred to herein as "The Company", "We", "Us" or "Our") for your life insurance needs. We greatly appreciate your efforts to complete each part of the application truthfully and accurately. The producer should be able to answer any questions you may have. This producer is not authorized to make or modify contracts or to waive any requirements or any information that We may request. This Notice tells you what to expect after completing the Application–Part I and provides other important information required by state laws and regulations.

UNDERWRITING

Once We receive your application, We will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for insurance. We may seek information from other sources to help Us in our evaluation. During underwriting, We may find that We are unable to give you the insurance you have applied for or that We are able to give it to you only on a modified basis or at a rate greater than Our lowest rate. For example, if you have ever used any kind of tobacco or any other nicotine product, you may not be eligible for Our lowest rate.

Your application will be Our primary source of information; therefore, it must be true, complete, and accurate. You must inform Us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. A claim may be denied or your coverage may be contested by a lawsuit if the application is incomplete or if it contains fraudulent statements or material misrepresentations. If the lawsuit is successful, the policy will be void and coverage will be lost. Any policy that is delivered to you will indicate when and under what circumstances it may be contested. Please be aware that if the application contains fraudulent or deceptive statements or conceals material facts, and you submitted it with the intent to defraud or to facilitate fraud against Us, you may also be guilty of insurance fraud, which is a crime.

REPLACEMENT OF EXISTING COVERAGE

If you intend to replace existing coverage, tell the producer of your intention and answer "yes" to the replacement question in the application; state law may require the producer to give you the information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. The following could be considered replacement: you stop paying premiums on an existing policy or surrender an existing policy before or shortly after applying to Us or you borrow from an existing policy to pay premiums for the insurance for which you are applying. State law may define replacement to include other situations. Ask the producer if you are unsure.

INSURANCE INFORMATION PRACTICES

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, We may ask a consumer reporting agency to collect information and submit an investigative consumer report to Us as explained in this Notice under The Fair Credit Reporting Act. You may request to be interviewed in connection with the preparation of this report.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appear in Our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate. We will send you a more detailed explanation of Our information practices if you send Us a written request. You may send your request to: The Savings Bank Mutual Life Insurance Company of Massachusetts, P.O. Box 4046, Woburn, MA 01888.

In certain limited situations, We are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

THE FAIR CREDIT REPORTING ACT

As part of Our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living, and personal characteristics. The agency will conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to Us within a reasonable time after you receive this Notice, We will tell you whether or not a report was requested. If a report was requested, We will tell you the name, address, and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you will like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

MEDICAL INFORMATION BUREAU DISCLOSURE

Information regarding your insurability will be treated as confidential. Savings Bank Mutual Life Insurance Company of Massachusetts or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company, for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you my contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734.

Savings Bank Mutual Life Insurance Company of Massachusetts, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

USA PATRIOT ACT

To help the government fight the funding for terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you apply for an insurance policy or annuity contract, We will ask for your name, address, date of birth, and other information that will allow Us to identify you. We may also ask to see your driver's license or other identifying documents.

PREMIUM PAYMENTS ON TERM AND WHOLE LIFE

For premiums not paid on an annual basis at the beginning of a policy year, We adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors and associated APRs are available and will be provided. Please ask the producer for more information.

BACKDATING DISCLOSURE

You may elect to backdate your policy, which enables you to gain benefits of a lower age for the purposes of determining the premium on your policy. There are some inherent costs associated with your decision to backdate your policy. For each month that your policy is backdated, the applicable premiums are accumulated and deducted from your initial premium payment. If you choose to pay your premiums by electronic funds transfer (EFT), your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment.

PRODUCER COMPENSATION

We would like you to understand how We pay the producer. When you purchase your insurance policy from Us, We pay compensation to the producer, who represents Us for such limited purposes as taking your application, collecting your initial premium and delivering your policy, and to any intermediaries through which the producer works. This compensation may include commissions when the policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation paid will vary based on the specific circumstances of your purchase. Additionally producers and/or their intermediaries may also receive additional commissions for each year a policy remains in force, bonuses, incentive trips or prizes associated with sales contests based on sales criteria, such as overall sales volume of a producer or intermediary, or for the percentage of completed sales. Intermediaries may also pay compensation directly to the producer. If the producer can sell insurance policies from other companies, these companies may pay compensation that differs from Ours.

ELECTRONIC TRANSACTIONS

We conduct business electronically and retain your documentation in electronic format. If you prefer Us to keep original copies of your documents, please notify Us within two weeks after the submittal of your application.

ABBREVIATED NOTICE OF INFORMATION PRACTICES

- Personal information about you may be collected from other parties.
- Personal and privileged information about you may, in certain circumstances, be disclosed to third parties without your specific Authorization.
- You have the right of access to all such personal information collected and you have the right to correct any erroneous or misleading personal information.
- Upon written request, We will provide you with a Comprehensive Notice of Information practices.

SBLI
— SINCE 1907 —

TRANSMITTAL FORM

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

Proposed Insured Name: _____ Date of Birth: _____

Proposed Plan: _____ Face Amount: _____

REQUIREMENTS

Status of Requirements:	**Enclosed**
● Application	☐
● Conditional Receipt	☐
• Cash/Check.....	☐
• Credit Card	☐
● APP Authorization	☐
• Voided Check	☐

Additional Requirements:	**Enclosed**	**Ordered**	**Date Ordered:**
● Replacement Forms	☐	☐	_____
● Inspection Report	☐	☐	_____
● Paramedical /Medical Exam	☐	☐	_____
• Company Name: _____			
● Blood/ HOSPEC	☐	☐	_____
● HIV/Consent Form	☐	☐	_____
● EKG (exercise)	☐	☐	_____
● EKG (resting)	☐	☐	_____
● APS: Dr's Name: _____	☐	☐	_____
● Other: _____	☐	☐	_____

Special Instructions or Requests:

Agency Name: _____ Agency Number: _____

Agency Contact: _____ Agency Phone No.: _____

Contact E-Mail: _____

SBLI
— SINCE 1907 —

PRODUCER REPORT FORM

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

A. PRODUCER INFORMATION

1. Full Name (First, Middle, Last.)	2. Producer Company #
3. Phone #: Fax #: Email:	4. Managing Agency/Brokerage Name: Phone #: Fax#: Email:

B. COMPLIANCE INFORMATION

1. Have you delivered the Notice (A-91D) to the Proposed Insured and Owner?.....□Yes □ No
2. Did you meet personally with the Proposed Insured and Owner and confirm their identification? *(If No, explain below)*.....□Yes □ No
3. If you accepted payment with this application, a Conditional Receipt Agreement (CRA) is required. Was a CRA given?.....□Yes □ No
4. To your knowledge, does the Owner intend to change ownership of the policy after issuance (i.e. to a trust, viatical or life insurance company or another person?.....□Yes □ No
5. Will any portion of the premiums for this policy be financed?.....□Yes □ No
6. Does the Proposed Insured have any existing life insurance or annuity?.....□Yes □ No
7. Is this Insurance applied for intended to replace, end or change any existing life insurance or annuity.....□Yes □ No

If you answered "Yes" to questions 5, 6 or 7 (above), replacement forms may be required by state law. Please include copies of any required forms with the application. If existing insurance may be replaced, ended or changed, attach a full explanation to the application and explain to the Owner and Proposed Insured that new suicide and contestable periods apply.

C. PROPOSED INSURED / OWNER INFORMATION

1. How well and how long have you known the Proposed Insured? _____
2. Are you related? □ Yes □ No If Yes, How?_____
3. If Proposed Insured is a minor, the amount of insurance on the parents are: Father _____Mother_____
   Siblings name(s) and coverage amount(s) _____
4. If parents and siblings do not have coverage, please explain. _____

D. REMARKS

E. LICENSED PRODUCERS TO RECEIVE COMMISSION: *Please complete for each Agent to receive commission. Total commission shares to equal 100%. Each Agent will share equally unless otherwise indicated.*

Full Name	Email	% Split	Company Number

F. ACKNOWLEDGEMENT

I represent to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and the Proposed Insured in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date of the application was taken.

_____ _____
Signature of Producer Date: Signature of Second Producer (if applicable) Date:

_____ _____
Print Name of Producer Print Name of Second Producer (if applicable)

CONDITIONAL RECEIPT AGREEMENT

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com
(Referred to in this receipt as "The Company", "we", "us', or "our")

_____
Name of Proposed Insured

A. NOTICE TO PROPOSED INSURED AND OWNER

No insurance coverage will become effective before delivery of the policy applied for unless and until all of the Conditions Precedent specified in Section C of this Conditional Receipt Agreement ("Agreement") are met. If any Conditions Precedent specified in Section C, below are not met, the Producer is not authorized to accept a premium and there will be NO COVERAGE. No Producer has the authority to alter or waive the terms or conditions of this Agreement. This Agreement shall be void if altered or modified.

B. PROPOSED INSURED'S REPRESENTATIONS

1. Has the Proposed Insured:
   a. in the past 5 years, been diagnosed or treated by a medical professional for unintentional weight loss; or been advised by a medical professional of any medical condition or impairment for which he/she has not consulted a physician or medical professional for follow-up treatment? ☐ Yes ☐ No
   b. in the past 5 years been treated for, been advised to be treated for, or been diagnosed with, by a medical professional, any type of heart disease or any other vascular disease; cancer; leukemia; malignant tumor; any disorder of the immune system; stroke; or alcohol or drug dependence or abuse? ☐ Yes ☐ No
   c. in the past 90 days been admitted as an inpatient in a hospital or other licensed health care facility; or undergone any type of surgical procedure performed by a medical professional; or been advised by a medical professional to undergo diagnostic or medical testing (excluding an AIDS-related test)? ☐ Yes ☐ No
   d. been diagnosed by a medical professional as having Hepatitis C, Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

2. Is the Proposed Insured less than 15 days or more than 70 years old (age nearest birthday), on the date this Agreement is signed? ☐ Yes ☐ No

C. CONDITIONS PRECEDENT WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY

1. All of the questions in Section B of this Agreement are answered "NO"; and
2. An amount equal to the modal premium indicated on the Life Insurance Application Part I must be received by us; the mode must be either annual, semi-annual, quarterly or monthly (two months' premium required); and
3. The Life Insurance Application Part II and any required additional Application Amendments (Questionnaires), all paramedical examinations, medical testing, laboratory testing and diagnostic testing, x-rays and/or electrocardiograms initially required by us with regard to age and amount of life insurance coverage applied for and the risk class applied for must be completed; and
4. The Proposed Insured is, on the Effective Date, a risk acceptable for life insurance coverage with us exactly as applied for to us, according to our rules and practices, without modification of plan, premium rate or amount; and
5. On the Effective Date the Proposed Insured's health and all factors affecting the insurability of the Proposed Insured for coverage as applied for with us must be as stated in the Life Insurance Application Part I, the Life Insurance Application Part II and any other application supplements or amendments required by us; and;
6. Any check, authorized withdrawal, credit card payment or any form of payment must be received by us and honored when first presented for deposit by us.

D. EFFECTIVE DATE

If all Conditions Precedent specified in Section C of this Agreement are completely satisfied, then insurance coverage, subject to all the terms and conditions of the policy applied for as if the policy applied for had already been issued and delivered, will become effective as of the latest of: (a) the date the Life Insurance Application Part I is signed by Proposed Insured and received by us; (b) the date the Life Insurance Application Part II is signed by Proposed Insured and received by us; (c) the date of completion of the paramedical examinations, medical testing, laboratory testing and diagnostic testing and all of our underwriting requirements stated in Section (C)(3), above; or (d) the special policy date requested in Section J of the Life Insurance Application Part I, if any.

E. MAXIMUM AMOUNT

The maximum amount of life insurance coverage available under this Agreement shall be the lesser of: (1) the amount of insurance applied for in the Life Insurance Application Part I; or (2) $1,000,000, less the amount of insurance on the Proposed Insured's life in force with us under any policies, riders and Conditional Receipt Agreements, applied for or pending issue with us, including Accidental Death Benefits, plus the amount of any premium paid for coverage in excess of this amount; or (3) if death is due to suicide or intentional self-inflicted injury, the amount of premium paid will be refunded and no death benefit will be paid. There is no coverage under this Agreement beyond 70 years old (age nearest birthday) or below age 15 days.

F. REFUND OF MONEY

We will refund your money on the earliest of the following dates: (1) If any of the Conditions Precedent specified in Section C above are not met; or (2) You refuse to accept a policy that we issued to you; or (3) 90 days from the date this Agreement is signed. Our liability will be limited to the return of the amount paid with this Agreement. All returns will be made, without interest, to or for the benefit of the Owner. We may send a notice or return premium terminating this Agreement at any time before delivery of the policy.

_____ Name of Proposed Insured

G: AGREEMENT

I represent that all statements and answers in this Agreement are: full; complete; and true to the best of my knowledge and belief. I agree that: (1) the limited amount of insurance that may begin prior to policy delivery will not exceed the Maximum Amount as defined in Section E of this Agreement; (2) this limited amount of insurance will not begin unless all of the Conditions Precedent specified in Section C of this Agreement are completely satisfied; (3) this Agreement will be void if this Agreement or Life Insurance Application Part I or Life Insurance Application Part II contain any material misrepresentations; or if the Proposed Insured dies by suicide or intentional self-inflicted injury; and (4) this Agreement will automatically end on the earliest of the following dates: (a) the date the entire amount paid with this Agreement is returned; or (b) the date the policy applied for is delivered to the Owner; or (c) 90 days from the date this Agreement is signed. I further agree to any remaining terms, limits, and conditions of this Agreement and Life Insurance Application Part I and Part II.

I understand and expressly agree that my payment provided with this Agreement has not purchased immediate life insurance coverage under this Agreement and that no life insurance coverage under this Agreement shall commence unless and until all Conditions Precedent to life insurance coverage specified in Section C under this Agreement have been satisfied completely.

Signature of Proposed Insured	Date	Signature of Owner/Applicant (if not Proposed Insured)	Date

H: PRODUCER/BROKER STATEMENT

On the date below, I received the amount $_____ from _____ in exchange for this Agreement. This Agreement bears the same date as the Life Insurance Application – Part I. I have accurately represented the terms and conditions of this Agreement to the Proposed Insured and Owner. I know of no reason why any person to be covered may not be eligible for insurance.

Signature of Producer	Date

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER. DO NOT LEAVE THE PAYEE BLANK. CASH AND MONEY ORDERS WILL NOT BE ACCEPTED.

The Savings Bank Mutual Life Insurance Company of Massachusetts
One Linscott Road, Woburn MA 01801
Telephone (800) 694-7254 ~ www.sbli.com

- IMPORTANT INFORMATION -
ACCELERATED BENEFIT RIDER

**TO BE GIVEN TO THE APPLICANT AT TIME OF APPLICATION (DIRECT SALE)
OR UPON POLICY DELIVERY (DIRECT RESPONSE SALE)**

PLEASE READ THE FOLLOWING DISCLOSURE ITEMS CAREFULLY

Your application to The Savings Bank Mutual Life Insurance Company of Massachusetts may include a Rider which, under certain defined circumstance, may allow for an accelerated distribution of a portion of the policy death benefit prior to the death of the insured.

This Rider provides for an Accelerated Benefit payment of life insurance proceeds. It is not intended or designed to provide health, nursing home, or long-term care insurance.

If an Accelerated Benefit is paid, a lien will be placed against the Policy Death Benefit equal to the amount of the Accelerated Benefit.

This Accelerated Benefit is intended to qualify as a terminally ill individual under Internal Revenue Code (IRC) section 101(g), and not as a chronically ill individual in that the Accelerated Benefit payable under this Rider does not and is not intended to qualify as long-term care insurance.

The acceleration-of-life-insurance benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated. If the acceleration-of-life-insurance benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration of- life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law.

Receipt of acceleration-of-life-insurance benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance

There is no premium charge for this Rider. However; there may be a Maximum Administrative Expense Charge of $150.00 deducted from the Accelerated Benefit.

When an Accelerated Benefit is paid under this Rider, a lien is created against the Policy Death Benefit. The lien is equal to the amount of the Accelerated Benefit. Any outstanding lien will continue against the Policy until the lien is repaid or the Policy ends. Establishing the lien may require the repayment of all or part of an outstanding Policy loan.

In order to qualify for an Accelerated Benefit, we must receive a request for payment and written proof that the Insured is living and has a Terminal Condition. A “Terminal Condition” is defined in the Rider as a medical condition resulting from injury or illness that is reasonably expected to result in the death of the Insured within the Qualifying Period of Life Expectancy (12 Months) from the date of a Statement from the Insured’s Attending Physician. This Terminal Condition must manifest on or after the issue date of the Policy.

If the defined requirements are met, an accelerated payment will be made to the Policy Owner. Before distribution of the Accelerated Death Benefit may be completed, we will provide a statement of the effects the Accelerated Death Benefit Payment will have on the policy values, and we must receive confirmation from the Policy Owner, any Irrevocable Beneficiary and any Assignee under the policy, that each of these parties agrees to the Accelerated Benefit Payment.

EFFECTS ON THE POLICY WHEN A LIEN IS OUTSTANDING

When a lien is outstanding under the Policy, it will affect the Policy's benefits and provisions as follows:

a. The dividends payable will be affected by any outstanding lien balance during the policy year.
b. The Policy's face amount will not be reduced by the lien. However, the Death Benefit payable when the Insured dies will be reduced.
c. The Policy's cash values will not be reduced by any outstanding lien. However the Cash Surrender Value available upon surrender will be reduced.
d. The available loan value of the Policy will be reduced by any outstanding lien.
e. If the Policy lapses and continues as extended term insurance while there is an outstanding lien, the outstanding lien will be deducted from the cash surrender value prior to determining the amount of the extended term insurance.
f. If the Policy lapses and continues as reduced paid-up insurance while there is an outstanding lien, the outstanding lien will not be deducted from the cash surrender value prior to determining the amount of the reduced paid-up insurance. The outstanding lien will continue in effect on the Policy. However if the outstanding lien exceeds the amount of the reduced paid-up insurance, the Policy will end at that time.
g. If the Policy lapses while a lien is outstanding and is later reinstated, the lien must either be repaid or reinstated.

If you have any questions concerning the above information, please contact your Insurance Provider, or you may contact The Savings Bank Mutual Life Insurance Company of Massachusetts at the address, telephone number, or through the website, as indicated at the top of this form

I certify that I have been provided a copy of this Accelerated Benefit Rider Disclosure.

_____	_____	_____	_____
Applicant Signature	Date	Agent Signature	Date

INDIVIDUAL LIFE INSURANCE APPLICATION
PART I

The Savings Bank Mutual Life Insurance Company of Massachusetts
SBLI.com

"You" and "Your" refer to the Proposed Insured. "SBLI" refers to The Savings Bank Mutual Life Insurance Company of Massachusetts

A. PRODUCT INFORMATION

1. Product:

☐ Term Life: ☐ 10Yr LT ☐ 15Yr LT ☐ 20Yr LT ☐ 25Yr LT ☐ 30Yr LT

☐ Whole Life: ☐ SL ☐ L10 ☐ L15 ☐ L20 ☐ L@65 ☐ SPL

☐ Other: _____

2. Insurance Policy Amount: _____

3. Riders/Additional Benefits:

☐ Single Pay Paid-Up Additions: $_____

☐ Term Rider: Plan_____ Amount: $_____

☐ Child Rider: $_____

☐ Flex Pay Paid-Up Adds: Scheduled Premium: $_____

☐ GPO: $_____

☐ Accidental Death: $_____

☐ Waiver of Premium

☐ Accelerated Death Benefit

☐ Other: _____

4. Site of Sale (*city, state*) _____

ADDITIONAL SERVICES

While your Policy is In Force, and if available on the product you elect, we may provide you with access to additional services such as cloud-based document storage.

B. PROPOSED INSURED INFORMATION

1. Full Name *(First, M.I., Last)*: _____ ____ _____

2. Sex: ☐ M ☐ F 3. Date of Birth *(mm/dd/yyyy):* ____ -____ - _____

4. Birth State & Country _____ 5. SSN: _____

6. Residential Address *(#, Street, City, State, Zip Code*): _____

7. Mailing Address *if different than residence (#, Street, City, State, Zip Code*): _____

8. Contact Information:

Home #: (__) ____ - _____ Cell #: (__) ____ - _____

Work #: (__) ____ - _____ E-mail: _____

Preferred mode of contact: _____

9. Driver's License #: _____ State where issued: _____

10. Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

# of dependents: _____ Ages of dependents: _____

_____
Name of Proposed Insured

11. U.S. Citizen? ☐ Yes ☐ No (If "No", complete a Citizenship Questionnaire)

12. Current Occupation: _____

13. Current Employer Name _____ Address: _____

14. How long employed? _____

15. Have you ever used tobacco, any other nicotine product, or nicotine by-product of any type?

☐ Yes ☐ No If "Yes"; Type: _____ How long used: _____

Last used: *(mm/yyyy):* ____ / _____ Amount & How often: _____

16. How much life insurance does your spouse have in force with all insurers, including SBLI? $_____

Is your spouse also applying for insurance with SBLI? ☐ Yes ☐ No If Yes, how much? $ _____

C. OWNER OF INSURANCE APPLIED FOR

Complete only if the owner is not the insured.

If Owner is an Individual:

1. Owner Name *(First, M.I., Last)*: _____ __ _____ 2. Date of Birth (mm/dd/yyyy) _____

3. Relationship to insured _____ 4. SSN _____ 5. E-mail _____

6. Home Phone #: _____ 7. Work Phone #: _____

8. Residential Address (#, Street, City, State, Zip)_____

9. Mailing Address, if different (#, Street, City, State, Zip) _____

10. U.S. Citizen? ☐ Yes ☐ No (If "No", complete the Citizenship Questionnaire)

If Owner is a Business:

☐ Corporation ☐ Partnership ☐ Sole Proprietorship

11. Name of Business: _____ 12. TIN/SSN: _____

13. Name of Responsible Officer, if applicable *(First, M.I., Last)*: _____ __ _____

14. State where Incorporated _____ 15. Phone Number: _____ 16. E-mail: _____

17. Billing Address *(#, Street, City, State, Zip Code)*_____

If Owner is a Trust:

18. Name of Trust: _____ 19. TIN: _____ 20. State where Incorporated: _____

21. Billing Address (#, Street, City, State, Zip Code):_____

22. Date of Trust (mm/dd/yyyy): _____ 23. Type of Trust ☐ Revocable ☐ Irrevocable

24. Trust Contact Name*(First, M.I., Last)*: _____ __ _____

25. Preferred Telephone #: _____

26. Address (#, Street, City, State, Zip):_____ 27. E-mail: _____

_____
Name of Proposed Insured

28. Does the above Trustee have sole authority to act on behalf of the Trust? ☐ Yes ☐ No

(If "No", list all Trustees below and obtain their signatures. Attach a separate page if more space is needed.)

Name of Trustee *(First, M.I., Last)*	Address	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. BENEFICIARY

If percentages are not shown, shares will be distributed equally. Total % of primary shares must equal 100%. Total % of contingent shares must equal 100%. Attach a separate sheet if more space is needed.

1. Primary Beneficiaries

Full Name *(First, M.I., Last)*	Address	Date of Birth	SSN or TIN	Relationship to Insured	% Share
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

2. Contingent Beneficiaries

Only in event that no Primary Beneficiary survives the Insured

Full Name *(First, M.I., Last)*	Address	Date of Birth	SSN or TIN	Relationship to Insured	% Share
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

3. If the beneficiary is a Trust or Business, is it the same as the above Owner?

☐ Yes ☐ No *(If "No", provide the following):*

Name of Trust or Business: _____ State where Incorporated _____ Date of Trust _____

_____
Name of Proposed Insured

List Trustees. Attach a separate page if more space is needed.

Full Name *(First, M.I., Last)*

_____

_____

_____

_____

_____

E. PROPOSED INSURED INSURANCE NEEDS

Complete either the Personal or Business Section. Explain "Yes" answers in the Details Section.

Personal Section

1. Purpose of Insurance: ☐ Income Replacement ☐ Business Insurance (if yes, complete Business Section below)
   ☐ Estate Conservation ☐ Charitable Gift ☐ Other (Specify): _____
2. Annual Income $_____ 3. Annual Household Income $ _____ 4. Net Worth $ _____
5. Within the last 5 years, have you filed for bankruptcy or had any judgments or liens filed against you?
   ☐ Yes ☐ No
6. If yes, has this been discharged? ☐ Yes ☐ No If yes, Date of Discharge:_____

Business Section (To be completed for Buy-Sell, Key Person, Business Loan Protection)

7. Purpose of Insurance: ☐ Buy-Sell ☐ Key Person ☐ Business Loan Protection ☐ Other (Specify): _____
8. Business Type:
   ☐ Corporation (LLC, S-Corp, C-Corp, Sole Proprietorship)
   ☐ Partnership (General Partnership (GP), Limited Partnership (LP), Limited Liability Partnership (LLP)
   ☐ Proprietorship ☐ Other
9. Year Business was established _____ 10. Business Net Worth: $_____ 11. Fair Market Value of the business: $ _____
12. Within the last 5 years, has the business filed for bankruptcy or had any judgments or liens filed against it?
   ☐ Yes ☐ No
13. If yes, has this been discharged? ☐ Yes ☐ No If yes, Date of Discharge:_____
14. What percentage of business is owned by you? _____% 15. Net profit after taxes: $_____
16. Gross Sales: $_____ 17. Gross Annual Income with Bonus: $_____
18. Amount of business insurance in force on Proposed Insured's life: $ _____
19. In the Details section (J):

a. If applicable, describe any insurance being applied for or that is in force on other key members of the business.

b. If applicable, describe why there is no insurance applied for or in force on other key members of the business.

_____
Name of Proposed Insured

F. PROPOSED INSURED PERSONAL HISTORY

1. Have you ever: (a) sold a life insurance policy; or (b) have you entered, or made plans to enter, an agreement to sell the policy being applied for; or (c) has any person promised, agreed to give, or given to any party to the application any inducement, fee or compensation to purchase the policy? *(If "Yes", provide details below)* ☐Yes ☐No

2. Do you have any other applications or informal inquiries for life insurance pending with any other company, society or association? *(If "Yes", provide details below)* ☐Yes ☐No

3. Have you ever had an application or reinstatement request for life or disability insurance: refused or limited; or have you been asked to pay a higher premium? *(If "Yes", provide details below)* ☐Yes ☐No

4. Do you intend to reside or travel outside of the United States or Canada in the next 12 months? ☐Yes ☐No

5. In the last 5 years, has your licensed been suspended or revoked, have you received any moving violations, or have you been convicted of reckless driving, driving to endanger, or driving under the influence of drugs or alcohol? *(If "Yes", provide details below)* ☐Yes ☐No

6. Have you ever been convicted of, or are you awaiting trial for a felony or misdemeanor, or are you currently on parole or probation? *(If "Yes", provide details below)* ☐Yes ☐No

7. Have you ever engaged in or, within the next 2 years do you intend to engage in, racing motorboats or motor vehicles, sky-diving or parachuting, hang-gliding, hot air ballooning, mountain, rock or ice climbing, or scuba diving? *(If "Yes", complete the appropriate Hazardous Activities and/or Aviation Questionnaire)* ☐Yes ☐No

8. Other than as a flight attendant or a passenger on a regularly scheduled airline, within the past 2 years have you flown as a pilot, student pilot or crew member or do you plan to do so within the next 2 years. *(If "Yes", complete the Aviation Questionnaire)* ☐Yes ☐No

9. Are you currently, or have you entered into a written agreement to become, a member of the Armed Forces (including the Reserves or National Guard)? *(If "Yes", complete the Military Questionnaire)* ☐Yes ☐No

For any "Yes" answers, record details below: Use the overflow sheet if more space is needed.	
Question #	Details

_____
Name of Proposed Insured

G. PREMIUM PAYMENT INFORMATION

If "EFT" or "Credit Card" please fill in an EFT or Credit Card form. Credit Card available only for Initial Payment

1. Initial Payment Method:
   ☐ Check ☐ Credit Card ☐ Electronic Fund Transfer (EFT) Other (Specify): _____
2. Payment Mode:
   ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (EFT only)
3. Send Premium Notices to:
   ☐ Insured ☐ Owner ☐ Other (Specify): _____
4. Would you like to back-date your policy to save age? ☐ Yes ☐ No *(If yes, see back-dating Disclosure section in the Notice Proposed Insured and Owner)*
5. Identify the person or entity that is paying the first premium for the insurance applied for:
   ☐ Insured ☐ Owner ☐ Other *(if other, provide details)*

   Payor Name *(First, M.I., Last)*: _____ Address: _____
   Relation to Insured: _____ Phone #: _____
6. Amount paid with Conditional Receipt Agreement (CRA): $_____
7. The Automatic Premium Loan Provision to be effective, if available, unless requested otherwise here: ☐ Not Effective

---

H. DIVIDEND OPTION

If none is selected or a selected option is not available, the default option will be Accumulate at Interest.
All dividends are paid at anniversary. Does not apply to non-participating policies.

1. ☐ Accumulate at Interest
2. ☐ Cash Dividend
3. ☐ Purchase Paid Up Life Additions
4. ☐ Reduce Premium Amount and/or Loan Interest Due. Any remaining Dividend Balance will Accumulate at Interest.
5. ☐ Not Applicable (Non-participating)

I. REPLACEMENT INFORMATION

Applies to both Owner and Proposed Insured. If you intend to replace existing coverage, please tell the Producer and answer "Yes" to replacement question #2 below. State law may require the Producer to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace it may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain, among other things, new suicide exclusions and contestability periods. Ask the Producer if you are unsure.

_____
Name of Proposed Insured

	Proposed Insured	Owner
1. Do you have an existing or pending life insurance policy or annuity contract with SBLI or any other company? (Do not include group policies) *(If "Yes", provide details below. Complete state required replacement form for New NAIC Model Replacement Regulation States only)*	☐Yes ☐No	☐Yes ☐No
2. Do you intend to replace or change any existing life insurance or annuity contract with the insurance applied for? *(If "Yes", complete state required replacement form and provide details below)*	☐Yes ☐No	☐Yes ☐No
3. Are you considering using funds from an existing policy or contract to pay premiums on the policy you are applying for? *(If "Yes", complete state required replacement form and provide details below)*	☐Yes ☐No	☐Yes ☐No
4. Have you stopped making premium payments, surrendered, forfeited, assigned to SBLI, or otherwise terminated an existing policy or contract or are you considering doing so? *(If "Yes", complete state required replacement form and provide details below)*	☐Yes ☐No	☐Yes ☐No

Insurance Companies (Do not include group policies)	Name of Insured	To be replaced?	Contract / Policy #	Cash Value / Amount of Coverage	Date of Issue
_____	_____	☐ Yes ☐ No	_____	$_____	_____
_____	_____	☐ Yes ☐ No	_____	$_____	_____
_____	_____	☐ Yes ☐ No	_____	$_____	_____

J. DETAILS

Use this section for explanations and special requests. Identify Question and Section numbers.

_____
Name of Proposed Insured

K. FRAUD WARNING

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

L. REPRESENTATIONS

I, the Owner and the Proposed Insured signing below, agree that I have read the statements contained in the application or they have been read to me. I understand that the application includes the Application – Parts I and II and all supplemental forms or amendments the Company specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner.

I acknowledge that my answers to the above questions may result in higher premium rates or a denial in coverage.

I understand and agree that no Producer is authorized to: (a) accept risks or pass upon insurability; (b) make or modify contracts; (c) waive SBLI's rights or requirements; or (d) waive any information SBLI requests.

I represent: (1) that the statements and answers I provided within the entire application are true, complete, and correct to the best of my knowledge and belief; (2) that SBLI, believing the statements and answers to be true, complete, and correct, shall rely and act on them (3) the insurance being applied for is suitable for the Owner's insurance needs.

Under penalty of perjury, I certify that: a) my Social Security Number provided herein is my correct taxpayer identification number; and b) I am not subject to backup withholding because 1) I am exempt from backup withholding, or 2) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or 3) the IRS has notified me that I am no longer subject to backup withholding.

The IRS does not require your consent to any provision of this document other than certification required to avoid backup withholding. CROSS OUT ALL OF SUBPART "b)" IN THE PRECEDING PARAGRAPH IF YOU ARE SUBJECT TO BACKUP WITHHOLDING.

_____
Name of Proposed Insured

M. AUTHORIZATION TO COLLECT AND DISCLOSE INFORMATION

This Authorization complies with the Health Insurance Portability and Accountability Act ("HIPAA")

I hereby authorize all the entities listed below that have provided payments, treatments or services to me, or on my behalf, to disclose to The Savings Bank Mutual Life Insurance Company of Massachusetts (SBLI) and its reinsurers, Producers, employees and representatives, including insurance support organizations, the following information: any and all information relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of alcohol, drugs, and tobacco; drug prescriptions and communicable diseases, including Human Immunodeficiency Virus (HIV) and AIDS, and any other personal information about me.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner or health care professional;
- any hospital, laboratory, pharmacy, pharmacy benefit manager, clinic or other health care facility or provider;
- any insurance or reinsurance company;
- any consumer reporting agency or insurance support organization; and
- my employer, group policy holder, or benefit plan administrator

This information may be disclosed pursuant to this Authorization so that SBLI can use it to:

- determine my eligibility for insurance;
- underwrite my application and make risk rating, policy issuance and enrollment determinations;
- determine my eligibility for benefits under the Conditional Receipt Agreement;
- obtain reinsurance;
- if a policy is issued, administer coverage, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and
- conduct other legally permissible activities that relate to any insurance coverage I have or have applied for with SBLI.

- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, medical practitioner, health care provider, hospital, clinic or any other health care provider to release and disclose my entire medical record without restriction. I understand that my health care providers cannot refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.
- I authorize the Company and its reinsurers to release any information obtained by this Authorization to other insurers in which I have policies or to which I may apply or to which a claim for benefits may be submitted, to reinsurers, and to other persons or organizations performing legal or business services in connection with my application or claim.
- I authorize MIB, LLC and its successor companies (MIB), and any MIB member insurer, to provide any medical or personal information that it has about me to the Company and its reinsurers or any MIB-authorized third-party administrator performing underwriting services on behalf of the Company. I also authorize the Company, its reinsurers or authorized third-party administrator, to make a brief report of my personal health information to MIB.
- I authorize the Company to release to me, or to my physician, results that I may request of any medical or laboratory tests taken in connection with this application. In connection with a claim for benefits, this Authorization is valid no longer than the duration of the claim.

_____
Name of Proposed Insured

- I also understand that failure to sign this Authorization statement, or subsequent revocation of this Authorization by me, may impair the ability of the Company to process my application or evaluate claims, and may be a basis for denying an application or claim for benefits.
- I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

- By signing below I agree to the terms of this Authorization and acknowledge that I have read and understand it.

FOR MAINE and VERMONT APPLICANTS, this Authorization excludes the release of any information relating to previously administered test for HIV antibodies, T-Cell counts, AIDS or ARC, by the applicants family/regular/attending medical doctor/physician/practitioner or care giver or any other person or entity which may possess this information. This exclusion extends to any medical doctor, doctor of osteopathy, physician health care professional, hospital, clinic, medical facility, the Veterans Administration, employer, consumer, reporting agencies, other insurance companies, or anyone else with respect to previous test results. The applicant is not authorizing the Company to forward the results from any new test, requested of the applicant by the Company to an outside, non-affiliated company, nor to any entity not under specific contract with the Company to perform underwriting services.

I may revoke this Authorization in writing at any time, except to the extent that action has been taken in reliance of this Authorization or to the extent the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself, by sending a written request to: The Savings Bank Mutual Life Insurance Company, P.O. Box 4048, Woburn, MA 01888.

This Authorization shall remain in force for 24 months or the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, following the date of my signature below or for the duration of any claim for benefits. A copy of this Authorization is as valid as the original. I acknowledge that I have received a copy of this Authorization.

Date: _____ Signature of Proposed Insured (Parent, Guardian, Other*): _____

*If the insured is under the age of 18, signature of ☐ Parent ☐ Guardian ☐ Other: _____

N. ACKNOWLEDGEMENT AND SIGNATURES

I acknowledge that I have received a copy, or I have been read a copy, of the Notice to Proposed Insured and Owner.

I agree that:
(a) I will notify SBLI if any statement or answer given in the entire application changes prior to policy delivery; and
(b) except as provided in the Conditional Receipt Agreement (CRA), if issued, I understand and agree that even if I paid a premium, no insurance will be in effect under this application, or under any new policy or any rider(s) issued by SBLI, unless the following three conditions are all met:

(1) the policy has been delivered and accepted;
(2) the full first modal premium for the delivered policy has been paid in full; and
(3) there has been no change in the health of the Proposed Insured that would change the answers to any questions in the application, or any amendments thereto, before conditions (1) and (2) above have occurred.

I understand and agree that if all three conditions are not met:
- no insurance coverage will become effective; and
- SBLI's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

_____
Name of Proposed Insured

Signature of Proposed Insured: X _____ Date _____

Signature of Owner/Applicant (if not Proposed Insured) X _____ Date _____

Signature of Producer X _____ Date _____

Producer Name Printed _____ Date _____

Signed at (City and State)_____

Producer # _____ License # _____

Signature of Producer X _____ Date _____

Producer Name Printed _____ Date _____

Signed at (City and State)_____

Producer # _____ License # _____

Rate applied for: _____

SBLI reserves the right to make administrative changes to the application. No administrative changes will be ascribed to the applicant.

O. PRODUCER INFORMATION and PRODUCER CERTIFICATION

1. Does the Applicant have existing life insurance policies or annuity contracts? (If Yes, submit the state applicable replacement form) ☐Yes ☐No
2. Do you have any knowledge or reason to believe that a replacement of an existing life insurance policy or annuity contract is involved in this transaction or that any funds from an existing policy or contract will be used to pay premiums on this applied for policy? ☐Yes ☐No
3. Do you have any knowledge or reason to believe that the proposed Owner or Applicant intends to change ownership of the policy now or in the future to an unrelated party such as a trust, viatical, life settlement company, bank and/or lending or investment company? ☐Yes ☐No
4. Do you have any knowledge or reason to believe that all or any part of the initial or future premium payments for this applied for policy may be directly or indirectly financed by an unrelated third party or be part of any loan arrangement? ☐Yes ☐No
5. Do you have any knowledge or reason to believe that the proposed Owner, Applicant or Insured has been offered any financial incentives as an inducement to apply for this proposed policy? ☐Yes ☐No
6. Have you received relevant anti-money laundering training within the last 24 months that was offered by SBLI, another life insurance company or a competent third party (e.g., LIMRA)? ☐Yes ☐No
7. Do you acknowledge that you are in compliance with your requirements as stated in SBLI's Producer's Guide to Anti-Money Laundering (AML) and are unaware of any AML Red Flags as described in your AML training? ☐Yes ☐No

- I certify that the responses herein are, to the best of my knowledge, information and belief complete and accurate.
- I certify that this policy has not been solicited, directly or indirectly for the benefit of an investor, stranger or unrelated third party.
- I certify that I am duly licensed in the state in which this application was signed.
- I have given the Proposed Insured the appropriate disclosure documents and have complied with state and federal statutes and regulations.
- I have reviewed the purchase of the life insurance policy as to suitability.

_____
Name of Proposed Insured

X _____ _____ _____
(Producer's Signature) (Producer's Printed Name) (Date)

Lead #:	Underwriting Stamp
Source:	
Rate Code:	
Process Date:	

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION
Part I

Name of Proposed Insured	Date of Birth	Social Security Number	Date of Application

Additional Details *(Use this space for explanations to any answers provided in application Part 1, or for any special requests. Identify applicable Question and Section numbers.)*

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Signature of Proposed Insured	Date	Signature of Owner/Applicant (if not Proposed Insured)	Date
Signature of Producer	Date	Signature of Producer	Date
Producer Name Printed		Producer Name Printed	

INDIVIDUAL LIFE INSURANCE APPLICATION
PART II

The Savings Bank Mutual Life Insurance Company of Massachusetts
SBLI.com

A. PROPOSED INSURED INFORMATION

1. Full Name *(First, Middle, Last):*_____ 2. Date of Birth *(mm/dd/yyyy):*_____

3. SSN: _____ 4. Build: a. Height ___ft. ___ in. b. Current Weight: _____ lbs.

c. Have you had any weight changes in excess of 10lbs. in the past year? ☐ Yes ☐ No
If Yes: Pounds Lost _____ Pounds Gained _____

d. Have you had any surgical treatment for weight loss? ☐ Yes ☐ No *(If Yes, explain in Section C DETAILS)*

5. Do you have a personal Physician or health care provider?: ☐ Yes ☐ No

If yes: Please provide the name of your Primary Personal Physician or health care provider that would have your up-to-date medical information. If more than one personal physician, provide name(s) in Section C DETAILS.

a. Physician/Health Care Provider:_____ b. Address: _____

c. Phone Number: _____ d. Date Last Consulted: _____

e. Reason for consultation: _____

6. In the last 5 years, have you consulted a physician or specialist other than your personal physician?: ☐ Yes ☐ No

If yes: Please provide the name of your Physician or health care provider you last consulted, if different from the above. If more than one, provide name(s) in Section C DETAILS.

a. Physician/Health Care Provider: _____ b. Address: _____

c. Phone Number: _____ d. Date Last Consulted: _____

e. Reason for consultation: _____

B. MEDICAL INFORMATION

Please answer ALL medical questions. Do not leave questions blank. Explain "Yes" answers in Section C Details.

1. Have you ever been advised by a licensed medical professional that you had or currently have any of the following:
   a. Elevated Blood Pressure or Elevated Cholesterol? ☐ Yes ☐ No
   b. Cancer, tumors; cysts; growths or polyps or any disorder of the skin? ☐ Yes ☐ No
   c. Depression, anxiety, attention deficit/hyperactivity, suicidal thoughts or attempts, anorexia or bulimia, or any other psychological, psychiatric, emotional, or mental disorders? ☐ Yes ☐ No
   d. Chest pain, heart attack, coronary artery disease, heart valve disorder, heart murmur, stroke/transient ischemic attack, irregular heart beat, peripheral vascular disease, aneurysm or any other disease or disorder of the heart or circulatory system? ☐ Yes ☐ No

_____
Name of Proposed Insured

e. Asthma, bronchitis, pneumonia, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, shortness of breath, or any other disease or disorder of the lungs or respiratory system? ☐Yes ☐No

f. Colitis, Crohn's disease, hepatitis, cirrhosis, or any other disease or disorder of the liver, pancreas, gallbladder, esophagus, stomach, or intestines? ☐Yes ☐No

g. Epilepsy, multiple sclerosis, Parkinson's disease, paralysis, Alzheimer's, dementia, memory loss, headaches, dizziness or fainting, Amyotrophic lateral sclerosis (ALS), Cerebral Palsy, or any other disease or disorder of the brain, nervous system, or neuro-muscular disorder? ☐Yes ☐No

h. Diabetes, high blood sugar, glucose intolerance, thyroid or pituitary disorder, or any other endocrine disease or disorder? ☐Yes ☐No

i. Disorder of kidney, bladder, prostate, blood or protein in the urine, or any disease or disorder of the genitourinary system? ☐Yes ☐No

j. Disorder of breast or reproductive organs? ☐Yes ☐No

k. Arthritis or any other disease or disorder of the muscles, bones, spine, or joints? ☐Yes ☐No

l. Anemia, coagulation or clotting disorder, or any other disease or disorder of the blood or lymph nodes? ☐Yes ☐No

m. Lupus, autoimmune disease or disorder, or connective tissue disease? ☐Yes ☐No

2. Are you currently receiving medical treatment or taking any other medication from a licensed medical professional that has not already been disclosed? ☐Yes ☐No

3. Do you have any doctor's visits, medical tests, medical care, or surgery recommended or scheduled by a licensed medical professional that has not been completed (excluding HIV)? If yes, please provide details in Section C DETAILS. ☐Yes ☐No

4. During the past 5 years, have you:
   a. Had an electrocardiogram, x-ray, blood test, or other diagnostic test excluding HIV test? ☐Yes ☐No
   b. Requested or received disability or compensation benefits? ☐Yes ☐No

5. Have you ever been diagnosed by a licensed medical professional, or tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ☐Yes ☐No

6. Have you ever:
   a. Used heroin, cocaine, crack, marijuana, ecstasy, PCP, LSD, amphetamines, barbiturates, opiates, or other illegal controlled or restricted substances except as prescribed by a licensed medical professional, or been advised by a licensed medical professional to seek treatment for addiction to prescription medication? ☐Yes ☐No
   b. Been advised, counseled, or received help or treatment by a licensed medical professional, or attended any organization to limit or discontinue the use of alcoholic beverages? ☐Yes ☐No

7. How many alcoholic drinks do you consume per week? _____

8. Family History
   a. Has a parent or sibling ever been diagnosed or treated by a licensed medical professional for coronary artery disease, cardiovascular disease, cerebrovascular disease, stroke, or cancer under the age of 60? ☐Yes ☐No
   b. Please complete the following:

	Age if Living	Age at Diagnosis	Age at Death	Cause of Death
□ Father	_____	_____	_____	_____
□ Mother	_____	_____	_____	_____

_____
Name of Proposed Insured

	Age if Living	Age at Diagnosis	Age at Death	Cause of Death
☐ Brother ☐ Sister	_____	_____	_____	_____
☐ Brother ☐ Sister	_____	_____	_____	_____
☐ Brother ☐ Sister	_____	_____	_____	_____
☐ Brother ☐ Sister	_____	_____	_____	_____
☐ Brother ☐Sister	_____	_____	_____	_____
☐ Brother ☐ Sister	_____	_____	_____	_____

C. DETAILS

For any "Yes" answers, identify applicable question. Provide details about conditions, diagnoses, dates, durations, treatments, tests, medications prescribed and names, phone numbers and addresses of all care providers and treatment facilities. If additional space is needed, use overflow form.

D. AGREEMENT AND SIGNATURES

I, the Proposed Insured signing below, agree that I have read all the statements contained in this entire application, or they have been read to me. I understand and agree that no Producer is authorized to (a) accept risks or pass upon insurability; (b) make or modify contracts; (c) waive The Savings Bank Mutual Life Insurance Company of Massachusetts's (SBLI) rights or requirements; or (d) waive any information the Company requests.

I represent: (1) the statements and answers given in the entire application are true, complete, and correct to the best of my knowledge and belief; (2) that the Company, believing the statements and answers to be true, complete, and correct, shall rely and act on them, and (3) the insurance being applied for is suitable for the Owner's insurance needs.

I acknowledge that I have received a copy or I have been read a copy of the Notice to Proposed Insured and Owner. I agree that:
(a) I will notify the Company if any statement or answer given in the entire application changes prior to policy delivery; and

_____
Name of Proposed Insured

(b) except as provided in the Conditional Receipt Agreement (CRA), I understand and agree that even if I paid a premium, no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless the following three conditions are all met:

(1) the policy has been delivered and accepted;
(2) the full first modal premium for the delivered policy has been paid in full; and
(3) there has been no change in the health of the Proposed Insured that would change the answers to any questions in the application, or any amendments thereto, before conditions (1) and (2) above have occurred.

I understand and agree that if all three conditions are not met:
- no insurance coverage will become effective; and
- the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

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

Signature of Proposed Insured X_____ Date:_____ City, State: _____

E. SIGNATURE(S) OF INTERVIEWER(S) – TO BE SIGNED BY ALL INTERVIEWERS, AS APPLICABLE

I certify that the information supplied by the Proposed Insured has been truthfully and accurately recorded on the Part II application.

If Producer recorded information:

Writing Producer Name: _____ Writing Producer Number:_____

Writing Producer Signature: X_____ Date: _____

Countersigned (Licensed resident Producer if state required): X_____ Date:_____

If Tele-interviewer recorded information:

Name (First, Last): _____

If Paramedical recorded information:
Examiner's Name (First, Last): _____ Phone Number: _____

Signature of Examiner X_____ Date _____ City, State _____

_____
Name of Proposed Insured

F. CUSTOMER IDENTITY INFORMATION

To be completed by producer or Paramed in physical proximity to the Proposed Insured (and Owner if different than Insured).

I have reviewed the Proposed Insured and Owner's (if applicable) identity document presented and recorded the following information:

Proposed Insured (and Owner if applicable) Name: (First, Middle, Last): _____

Proposed Insured Address: *(#, Street, City, State, Zip Code*): _____

Type of ID (Individual) (e.g. Drivers License): _____

Type of ID Document (Corporation/Trust) (e.g. Certificate of Good Standing or Trust): _____

ID Number: _____ Expiration Date: _____

Signature of Producer or Paramed Authenticating Customer's Identity:

X_____ Date _____

Producer/Paramed Number _____

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION PART II

Name of Proposed Insured	Date of Birth	Social Security Number	Date of Application

I hereby request that the application on the life of the Proposed Insured be amended to include the following:

C. DETAILS *For any "Yes" answers. Please identify applicable Question.*

State conditions, diagnoses, dates, durations, treatments, tests, medications prescribed and names, phone numbers and addresses of all care providers and treatment facilities.

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Signature of Proposed Insured	Date	City, State
If Producer recorded information:		
Signature of Writing Producer	Date	City, State
If Tele-interviewer recorded information:		
Name		Date
If Paramedical recorded information:		
Examiner's Name	Date	Phone Number

The Savings Bank Mutual Life Insurance
Company of Massachusetts
One Linscott Road, Woburn MA 01801
Telephone (800) 694-7254 ~ www.sbli.com

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations: Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result: The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results: All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result: If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurers as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:

_____

Address:

_____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent: I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____	_____	_____
Print Name of Proposed Insured	Signature of Proposed Insured or Parent/Guardian	Date

Address: _____

_____

The Savings Bank Mutual Life Insurance Company of Massachusetts
One Linscott Road, Woburn MA 01801
Telephone (800) 694-7254 ~ www.sbli.com

IMPORTANT NOTICE TO INSURANCE CUSTOMERS

- The insurance product or annuity you are considering purchasing is not a deposit or other obligation of, or guaranteed by the bank or any of its affiliates.

- This insurance product or annuity is not insured by the FDIC, any other agency of the United States, or the bank and its affiliates.

- If the insurance product or annuity you are considering purchasing contains investment risk there is a possibility that it may suffer a loss of value. Variable insurance products contain this risk.

I hereby acknowledge that I have reviewed the above disclosures with the sales representative or agent and have been provided an opportunity to discuss any questions that I may have had.

_____ _____

Customer Signature Date

☐ The above disclosures were provided orally to the customer.

_____ _____

Agent Signature Date

The Savings Bank Mutual Life Insurance Company of Massachusetts

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

CERTIFICATE OF NO ILLUSTRATION

This form applies only to whole life, universal life, or yearly renewable term life policies.

This form is to be completed at the time of, and submitted with, the Application when no sales illustration is presented to the Applicant when selling a life insurance policy, or when the Applicant applies for a policy other than as illustrated.

APPLICANT'S CERTIFICATION AND SIGNATURE

By signing, I acknowledge that:

(a) no life insurance sale illustration has been given to me for the policy for which I have currently applied; and

(b) I understand that an illustration conforming to any policy that may be issued will be provided on or before the delivery of such policy.

Signature of Proposed Insured	Date	**Signature of Owner/Applicant (if not Proposed Insured)**	Date
X_____		**X**_____	

PRODUCER'S CERTIFICATION AND SIGNATURE

By signing, I certify that I did not present an illustration to the Applicant that conforms to the policy applied for.

Signature of Producer	Date	**Signature of Producer**	Date
X_____		**X**_____	
Producer Name Printed		Producer Name Printed	
License # / Producer #		License # / Producer #	

The Savings Bank Mutual Life Insurance
Company of Massachusetts
One Linscott Road, Woburn MA 01801
Telephone (800) 694-7254 ~ www.sbli.com

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

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 life insurance policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new life insurance policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing life insurance policy or contract, or an existing life insurance 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 life insurance policy values, including accumulated dividends, of an existing life insurance policy to pay all or part of any premium or payment due on the new life insurance policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your life insurance policy or contract. You may be able to make changes to your existing life insurance policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing life insurance policy 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 and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or contract? ..... ❑ Yes ❑ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new life insurance policy or contract? ..... ❑ Yes ❑ No

If you answered "yes" to either of the above questions, list each existing life insurance policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the life insurance policy or contract number if available) and whether each life insurance policy or annuity contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			
4.			

Make sure you know the facts. Contact your existing company or its agent for information about the old life insurance policy or contract. If you request one, an in-force illustration, life insurance policy summary, or available disclosure document must be sent to you by the existing insurer. Ask for and keep all sales material used by the insurance producer in the sales presentation. Be sure you make an informed decision.

The existing life insurance policy or annuity contract is being replaced because:

_____

I certify that the responses herein are, to the best of my knowledge, accurate.

_____	_____	_____
Applicant's Signature	Applicant's Printed Name	Date
_____	_____	_____
Producer's Signature	Producer's Printed Name	Date

(Original - Home Office, 2nd Copy - Applicant, 3rd Copy - Producer)

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing life insurance policy or contract and the proposed life insurance policy or contract. One way to do this is to ask the company or insurance producer that sold you your existing life insurance policy or contract to provide you with information concerning your existing life insurance policy or contract. This may include an illustration of how your existing life insurance policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare life insurance policies or contracts. You should discuss the following with your insurance producer to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
Could they change?
You're older-- are premiums higher for the proposed new life insurance policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first 2 years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other life insurance policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

If this transaction is a replacement of a SBLI policy, I understand that credit will be allowed for the period of time that has elapsed under the replaced policy's incontestability or suicide period up to the face amount of the policy.

THE SAVINGS BANK MUTUAL LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)
One Linscott Road, Woburn, MA 01801 800-694-7254

NOTICE AND CONSENT FORM
EMPLOYER-OWNED LIFE INSURANCE

Name of Employer (hereinafter "the Company"): _____

Name of Employee/Director of Company: _____

Social Security Number: _____ Gender: _____

Date of Birth: _____ Age Nearest Birthday (Cannot Exceed 65) _____
(Month) (Day) (Year)

Home Address: _____ _____ _____
(Street) (City or Town) (Zip Code)

Business Address: _____ _____ _____
(Street) (City or Town) (Zip Code)

Check One of the Following:

____ I consent to have life insurance purchased on my life for the benefit of the Company, and I acknowledge that the Company has an insurable interest on my life. I have been advised that the maximum face amount of insurance to be purchased on my life at the time of issue will be no more than
$ _____

I have received a written explanation from the Company, understand the reason(s) for this life insurance and agree to have insurance placed on my life. I agree that the Company will have all of the rights of ownership, will pay all premiums, and will be the named beneficiary of the life insurance policy. I understand and agree that my administrators, estate, heirs, and assignees have no rights to any policy proceeds or benefits, unless specifically agreed otherwise in a separate written agreement between the Company and me. I further understand the Company may keep a life insurance policy, or policies, in effect on my life after my employment (or service as Director) with the Company has ended.

____ I do not consent to have life insurance placed on my life by the Company. I understand that my declining to provide consent will not adversely affect my employment (or my service as Director).

_____ _____ _____
EMPLOYEE NAME (Please Print) EMPLOYEE SIGNATURE DATE

POLICY E-APPLICATION & E-DELIVERY AUTHORIZATION & DISCLOSURE

For your convenience, The Savings Bank Mutual Life Insurance Company of Massachusetts ("SBLI") offers an electronic application ("e-application") process as well as the optional electronic delivery[1] ("e-delivery") of your policy. Please read the following terms and conditions regarding these services, then confirm your agreement by clicking the appropriate box(es) and signing and dating this form in the allocated space below.

- Your consent to completing your application electronically, receiving any related documents electronically and the e-delivery of your policy is voluntary as you may withdraw your consent or request a paper copy of your policy by calling Customer Service at 1-800-694-7254 or emailing SBLI at records@sbli.com. Your consent here only applies to your e-application, receipt of any related documents electronically and the e-delivery of your policy. These services also require internet access and software enabling you to open & save pdf documents. Free pdf software is available at https://get.adobe.com/reader/.

- Should you have any additional questions or concerns regarding your e-application, the e-delivery of your policy or if your email address changes please contact SBLI by emailing us at records@sbli.com or calling Customer Service at 1-800-694-7254.

☐ I consent to completing my application and receiving any related documents electronically.

☐ I consent to the e-delivery of my policy.

By signing below, I confirm that: I can access and read this POLICY E-APPLICATION & E-DELIVERY AUTHORIZATION & DISCLOSURE; I can print, save or send this document to a secure place for future access; and until or unless I notify SBLI as described above, I hereby consent to the electronic transactions I selected above.

X_____
Signature & Date

_____
Email Address

[1] Not all policies are eligible for e-delivery. Policies ineligible for e-delivery may include, but are not limited to: policies where the policy owner is different from the proposed insured; policies with incomplete application forms or missing signatures; policies with invalid or incorrect customer email addresses.

INTERNATIONAL BROKERAGE AGENCIES, INC.

HIPAA AUTHORIZATION RELEASE
TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured

Please Print

_____ _____/_____/_____

First MI Last DOB Month/Day/Year

I authorize any person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insurer, reinsurer, insurance support organization, the Medical Information Bureau, Inc., consumer report agency, state motor vehicle agency, employer, or any other person or institution to release to each of the insurance companies listed below, as well as to their reinsures, any insurance support organizations, those person authorized to represent them; and International Brokerage Agencies, Inc.; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputations, finances, occupations, other personal traits, drug and/or alcohol use and driving record for me and my minor children who are to be insured. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

- Aetna Companies
- Allstate Health Solutions
- American National
- APPS
- Brighthouse Life
- Corebridge
- ExamOne
- Express Imaging Services
- Fidelity Life
- Gerber
- Global Atlantic
- Illinois Mutual
- IMG
- J&H
- John Hancock
- Kemper
- Legal & General
- Lincoln Financial Group
- MassMutual
- Mutual of Omaha
- Nationwide
- North American
- OneAmerica
- Pacific Life
- Principal Life
- Protective
- Prudential
- SBLI
- Securian Financial
- Symetra
- Transamerica
- World Trips

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPPA protected health information do not apply for purposes of this authorization and I instruct my physician, health care professional, hospital, clinic, medical facility or any other health care provider to release and disclose my entire medical record without restriction to International Brokerage Agencies, Inc. I understand that any information that it is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, disability income, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt, or evaluation of insurance applications or prospective applications of the insurance companies listed above and their re-insurers as well as International Brokerage Agencies, Inc. and its staff, employees and affiliated companies.

I understand and agree that this form is not an application for life insurance and that no life insurance coverage is provided in connection with this form.

This authorization shall be valid for twenty-four (24) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand I may revoke this authorization in writing at any time by providing that written notification to International Brokerage Agencies, Inc. at the service address below. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned, absent any provision of any applicable state statute regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under. I understand that if I refuse to sign this authorization, International Brokerage Agencies, Inc. may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health services if I refuse to sign this authorization.

_____ _____

Signature of Proposed Insured Name of Proposed Insured

_____ _____ _____

City State Month/Day/Year

International Brokerage Agencies, Inc.
P.O. Box 1345, Joshua, TX 76058
Phone: (817) 752-4980; Fax: (817) 752-4982