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** ***I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted to the amount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 within the last five years been treated for or been diagnosed as having by a member of the medical profession:

   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)? California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. ❑ 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 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.

The falsity of any statement in the application for this policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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

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

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