BOSTON MUTUAL LIFE INSURANCE COMPANY

120 Royall Street • Canton, MA 02021 1-800-669-2668 Ext. 286

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.

EMPLOYEE/EMPLOYER

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 *(if pregnant, pre-pregnancy 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 _____

INSURANCE

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

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

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

1. 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** ***I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted only for misstatement of age or sex.***

2. In the past 5 years, have ANY of the proposed insureds been diagnosed, treated, tested positive for or been given medical advice by a licensed medical professional that they had: A) sleep apnea, asthma or emphysema; B) high blood pressure, stroke chest pain, transient ischemic attack (TIA), heart or circulatory disease or disorder; C) intestinal disease or disorder or ulcer; D) diabetes; E) leukemia, cancer, tumor or malignancy; F) epilepsy, mental or nervous disease or disorder including but not limited to depression or Bipolar disorder; G) kidney or genito-urinary disease or disorder; H) disorder of the back, muscles, bones or joints including but not limited to degenerative disc disease, spinal stenosis, Spina Bifida, or arthritis; I) liver disease or disorder; J) pancreatitis (new or acute); or K) thyroid disorder? ❑ YES ❑ NO
3. In the past 5 years, have ANY of the proposed insureds been treated for or been diagnosed by a licensed medical professional as having positive test results based on a positive HIV ELISA test followed by a re:active Western Blot Assay on the same specimen, for the purpose of obtaining insurance? ❑ YES ❑ NO
4. 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 performed by a licensed medical professional which you were told by that professional yielded other than normal results? ❑ YES ❑ NO
5. In the past 5 years, have ANY of the proposed insured: used any (1) opiate, (which includes opium, morphine, codeine, heroin, or opiods); (2) central nervous system depressants (which includes barbituates, nonbarbituate depressants or sedatives and benzodiazepines); (3) central nervous system stimulants (including cocaine and amphetamines); (4) hallucinogens; or (5) cannabis; used prescription medication other than as prescribed; been treated for alcoholism or drug use or dependency; or been advised by a medical professional to seek treatment for alcoholism, drug abuse or drug dependency? ❑ YES ❑ NO
6. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having memory loss? ❑ YES ❑ NO
7. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Amytrophic Lateral Sclerosis (ALS)? ❑ YES ❑ NO
8. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having autism? ❑ YES ❑ NO
9. In the past 2 years, have any of the proposed insureds been treated, examined or advised by a licensed medical professional for attempted suicide? ❑ YES ❑ NO
10. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Huntington's Chorea? ❑ YES ❑ NO

To be Completed if Applying for Disability Insurance

11. Are ANY of the proposed insureds currently pregnant? ❑ YES ❑ NO

Details for questions 2-11 answered "YES". Include question number. *(Attach additional details on a signed and dated separate sheet)*

Name	Medical Condition	Date(s)	Details/Treatment	Name & Address of Attending Physicians and Hospitals

AUTHORIZATION TO OBTAIN INFORMATION

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. *(formally known as Medical Information Bureau, Inc.)*, 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, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

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

MIB REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

CONSUMER REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report, which may include a report from MIB, Inc. *(formerly Medical Information Bureau, Inc.)* on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

REPRESENTATIONS AND NOTICE TO APPLICANTS

I/we have read the Evidence of Insurability form and represent that the statements and answers 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.

CAUTION: The falsity of any statement in the application for any policy covered by this chapter 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 rick or the hazard assumed by the insurer.

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

MUST BE USED WITH HIPAA FORM DESIGNATED FOR YOUR STATE