BOSTON MUTUAL LIFE INSURANCE COMPANY

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

BOSTON MUTUAL LIFE INSURANCE COMPANY – 1891–

FAMILY MATTERS. NO MATTER WHAT.®

CRITICAL ILLNESS AND HEALTH SCREENING BENEFIT CLAIM KIT

INSTRUCTIONS FOR FILING A CRITICAL ILLNESS CLAIM

1. Please complete Section 1 - Claimant's Statement.
2. Please complete Section 2 - Critical Illness Information. *(If additional space is needed to include all names of doctors or hospitals, please attach a separate piece of paper)*
3. Please read and sign the appropriate HIPAA compliant authorization. This is located on our website at www.bostonmutual.com. *(The authorization will help us obtain any additional medical information needed to complete the processing of your claim. By not completing the authorization, this could delay the processing of your claim.)*
4. Please have your attending physician complete Section 4, Attending Physician's Statement.
5. If you wish to receive your proceeds via direct deposit to your banking account, please be sure to complete the enclosed EFT Authorization form and include it with your other claim paperwork when you send it in.

INSTRUCTIONS FOR FILING A HEALTH SCREENING CLAIM

1. Please complete Section 3 - Health Screening Claim form.
2. Attach medical documentation which indicates the type of test performed and the date the test was performed.

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

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SECTION 1 – CLAIMANT'S STATEMENT *(Please Print)*

Insured Name *(Last, First)*	Social Security #	Date of Birth *(mo-day-yr)*	Certificate #

Address *(City, State, Zip)*	Phone Number

Patient's Name	Relationship to Insured	Patient's Date of Birth *(mo-day-yr)*	Patient's Date of Death *(if applicable)*

SECTION 2 – CRITICAL ILLNESS INFORMATION

What is the specific Critical Illness: ***(Please check appropriate box)***
Please note: Not all illnesses listed below are eligible for coverage. Please refer to your policy for a list of covered illnesses.

- ☐ Cancer/Carcinoma In Situ/Skin Cancer
- ☐ Myocardial Infarction *(Heart Attack)*
- ☐ Coronary Artery Bypass Surgery/Angioplasty/Stent
- ☐ Alzheimer's Disease
- ☐ Cerebral Palsy/Cleft Lip or Palate/Down Syndrome/Cystic Fibrosis/Spina Bifida
- ☐ Amyotrophic Lateral Sclerosis *(ALS)*
- ☐ Renal Failure *(Kidney Failure)*
- ☐ Major Organ Transplant *(Covered Organs: heart, lung, liver, kidney or pancreas)*
- ☐ Paralysis
- ☐ Severe Burns
- ☐ Coma
- ☐ Stroke
- ☐ Loss of Sight/Speech/Hearing
- ☐ Occupational HIV
- ☐ Benign Brain Tumor

Date critical illness diagnosed _____ Have you ever had the same or similar condition? YES ☐ NO ☐

If Yes, please explain _____

On what date did you first consult a medical practitioner in connection with your critical illness? _____

Please indicate the name and address of the Physician seen:

Name and Specialty: _____

Street Address: *(City, State, Zip)* _____

Please provide the name and address of the Primary Care Physician:

Name: _____

Street Address: *(City, State, Zip)* _____

If the Critical Illness required hospitalization, provide the name and address of the treating facility and dates of confinement:

Name of Facility: _____ Date Hospitalized from: _____ to _____

Street Address: *(City, State, Zip)* _____

Please provide details of any other doctors or specialists who have been consulted in connection with this critical illness:

Name	Address	Dates Seen

If policy has been in force less than 2 years, please provide the names and address of all physician's, not mentioned above, that have been consulted in the past 5 years:

Name	Address	Dates Seen

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge.

Please refer to the "Fraud Warning Notices" insert for your state.

X _____ _____ _____

Signature of Claimant | Printed Signature | Date

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SECTION 3 – HEALTH SCREENING/GENETIC TESTING BENEFIT CLAIM KIT

INSTRUCTIONS FOR FILING A HEALTH SCREENING/GENETIC TESTING CLAIM

1. Please complete Claimant's Statement.
2. Please complete Health Screening/Genetic Testing Information.
3. Please review, sign and date the form.
4. Attach medical documentation which indicates the type of test performed and the date the test was performed.
5. If you wish to receive your proceeds via direct deposit to your banking account, please be sure to complete the enclosed EFT Authorization form and include it with your other claim paperwork when you send it in.

CLAIMANT'S STATEMENT *(Please Print)*

Insured Name *(Last, First)*	Claimant's *(Patient)* Name	Certificate #
Address *(City, State, Zip)*		
Telephone Number	Claimant's Date of Birth *(mo-day-yr)*	Insured's Social Security #

HEALTH SCREENING/GENETIC TESTING INFORMATION

DATE TEST PERFORMED _____

WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED?

- ☐ Stress Test on a Bicycle or Treadmill
- ☐ Lipid Panel *(Total Cholesterol Count)*
- ☐ CA 15-3 *(Blood Test for Breast Cancer)*
- ☐ Serum Protein Electrophoresis *(myeloma)*
- ☐ CEA *(Blood Test for Colon Cancer)*
- ☐ PSA *(Blood Test for Prostate Cancer)*
- ☐ Fasting Blood Glucose Test
- ☐ Electrocardiogram *(EKG)*
- ☐ CA 125 *(Blood Test for Ovarian Cancer)*
- ☐ Hemocult Stool Analysis
- ☐ GENETIC SCREENING TEST
- ☐ Thermography
- ☐ Bone Marrow Testing
- ☐ Mammography/Breast Ultrasound
- ☐ Blood Test for Triglycerides
- ☐ Flexible Sigmoidoscopy
- ☐ Pap Smear *(including ThinPrep Pap Test)*
- ☐ Biopsy for Skin Cancer
- ☐ Oral Cancer Screening using ViziLite OraTest or similar test
- ☐ Chest X-Ray
- ☐ Colonoscopy

Please note: Not all tests listed above are eligible for coverage. Please refer to your Policy for a list of covered tests.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge.

Please refer to the "Fraud Warning Notices" insert for your state.

X _____ _____ _____
Signature of Claimant | Printed Name | Date

If you should need assistance in the completion of this claim form

Please call (877) 212-2950

*** * * SEND COMPLETED CLAIM FORM TO ABOVE ADDRESS OR FAX TO (781) 770-0492 * * ***

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SECTION 4 – ATTENDING PHYSICIAN'S STATEMENT

• PARALYSIS •

Patient's Name: _____ Date of Birth: _____ Certificate #: _____

COVERED CONDITIONS ARE LIMITED TO THE FOLLOWING

The term *"Paralysis"* means the permanent, total and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence.

PLEASE NOTE: Policy/certificate language and definitions may vary based on state and policy form variations. The actual policy/certificate language and definitions will control.

1. Date the patient suffered Paralysis as defined above: _____
2. Please provide a brief outline of the medical history leading to your patient's paralysis.

   _____

   _____
3. If paralysis was not a result of an accident, when did your patient first suffer symptoms or become aware of this condition?
   _____ What limbs are affected? _____
4. Was the patient confined on an inpatient basis in a hospital for more than 30 days? YES ☐ NO ☐
5. Are there any treatments that could improve the paralysis? YES ☐ NO ☐
6. Is the condition permanent without **ANY** likelihood of improvement? YES ☐ NO ☐
7. Please provide the names and addresses of other physicians who attended this patient for this or any other related condition.
   Name Address

   _____

   _____

   _____

ATTENDING PHYSICIAN'S SIGNATURE

I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

Name _____ Specialty _____ Telephone # _____
(Attending Physician) Please Print

Address _____
(City, State, Zip Code)

Signature _____ Date _____ Fax # _____

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AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Name: _____ Policy No: _____

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

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

Full Legal Name on Bank Account: _____

Name of Bank/Financial Institution: _____

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

Account #: _____

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

Disclosures

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

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

Date: _____ Signature of Claimant/Beneficiary: _____

Claim Services | ClaimsDept@bostonmutual.com

NOTICE OF INFORMATION PRIVACY PRACTICES

Boston Mutual Life Insurance Company
(Herein referred to as "we", "us", "our")

BOSTON MUTUAL LIFE INSURANCE COMPANY -1891-

FAMILY MATTERS. NO MATTER WHAT.®

PROTECTING YOUR INFORMATION

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

COLLECTING INFORMATION

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

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

SHARING INFORMATION

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

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

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

ACCESS TO YOUR INFORMATION WE HAVE IN OUR RECORDS

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

AMENDMENTS TO YOUR INFORMATION

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

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

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

420-012 3/15

FRAUD WARNING NOTICES – For Use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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

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

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

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

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

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

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

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

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

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

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

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

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

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

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

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

see other side

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

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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

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

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

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

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

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

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

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

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

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

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

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

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.