Life insurance Application for (check one): ☐ Employee ☐ Spouse ☐ Employee & Children ☐ Spouse & Children

Name of Your Employer: _____

Application is hereby made to the BOSTON MUTUAL LIFE INSURANCE COMPANY for the insurance benefits specified below. It is understood that the Company shall incur no liability because of this application prior to the Date of Issue of any policy issued on the basis of this application, nor unless and until this application is approved by the Company and the first premium is paid while the health or other conditions affecting the Insurability of the Insured are as described in this application.

ADMINISTRATOR USE

Issue Date: ☐☐ ☐☐ ☐☐ **Deduction Amount:** ☐☐☐.☐☐ **per 5K:** _____ **Emp. No.:** ☐☐☐☐☐☐☐☐☐

Month Day Year

Association ID: ☐☐☐☐ **Policy No.:** ☐☐☐☐☐☐☐☐ **Medical** ☐ **Reins.** ☐

TO BE COMPLETED BY PROPOSED INSURED

Soc. Sec. No. ☐☐☐ ☐☐ ☐☐☐

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Sex (M or F)** ☐ **Marital Status (circle one)** **Single** **Married**

Last First MI

Street Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Birthdate** ☐☐ ☐☐ ☐☐

Mos. Day Year

City ☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐☐☐☐ **Date of Hire** _____

State Zip Code

Email _____ **Employee Tel. Ext.** _____

Home Tel. No. _____

Spouse's Name

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐ ☐☐

Last First MI Mos. Day Year

1. **Dependent Children (Only if coverage is desired):**

Child's Name **Date of Birth**

_____

_____

_____

_____

PLAN

Dependent Children Coverage:

☐ Yes ☐ No

Amount of Employee or Spouse Life Insurance $ _____

$100,000 AD&D Benefit: ☐ yes ☐ no

☐ Weekly Paid ☐ Monthly Paid

☐ Bi-weekly Paid

☐ Irregular Part-Time Employee

☐ Semi-monthly Paid

Is this a change in your existing coverage under this Plan? Yes ☐ No ☐ (If "YES" "How do I Change my Existing Coverage?" see brochure.

EXISTING AMOUNT OF COVERAGE $ _____

EXISTING POLICY NO. _____

NEW TOTAL AMOUNT OF COVERAGE $ _____

ADMINISTRATOR USE ONLY

FILE NUMBER	FROM	2	3	4	5	6	7	8	SIGNATURE	PAYROLL DEDUCTION AUTHORIZATION	NEW	EXISTING
HOSPITAL TEL EXT.		OCC										

2. **BENEFICIARY: On death of Proposed Insured pay proceeds to:**

_____ _____

Relationship Name

MEDICAL INFORMATION

(TO BE COMPLETED BY PROPOSED INSURED)

1. Height: _____ft. _____in. Weight: _____lbs.
2. Will this insurance replace, change or modify any other existing insurance or annuities on any life to be insured? Yes ☐ No ☐
3. Have you used any form of tobacco within the last 12 months? Yes ☐ No ☐

(CONTINUED ON REVERSE)

4. Has any person to be insured been treated for any blood disorder or immune deficiency, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or have you tested positively for antibodies to the AIDS virus (Human T. Cell Lymphotropic Virus, HIV)? yes ☐ no ☐
5. Is any person to be insured now being treated or taking medicine for any condition or disease? yes ☐ no ☐
6. Has any person to be insured ever had, been told they had, or been treated or tested for: Diabetes, Cancer, high blood pressure, venereal disease, diseases or defects of the heart, blood, lungs, brain, kidneys, nervous or digestive systems? yes ☐ no ☐
7. Has any person to be insured consulted a physician for any reason during the last 5 years? yes ☐ no ☐
8. Has any person to be insured ever:
   a. Been advised to have any diagnostic test, hospitalization or surgery which was not completed? yes ☐ no ☐
   b. Been in a hospital, sanitarium or other institution for observation, rest, diagnosis or treatment? yes ☐ no ☐
   c. Used on more than one occasion, or is any such person now using, valium or other tranquilizers; barbiturates or other sedatives; marijuana, cocaine, hallucinogens or other mood altering drugs, heroin, methadone or other narcotics or controlled substances, except as legally prescribed by a doctor? yes ☐ no ☐
   d. Been treated or counseled for alcoholism, or other drug dependency? yes ☐ no ☐
   e. Had life or health insurance declined, postponed, changed, rated-up or withdrawn? yes ☐ no ☐
9. What are the full details of the answer to each part of Questions 5 through 8 which are answered "YES"?

Name & Question No.	Illness, operation or other cause, Reason for any check-up, doctor's advice, treatment and medication	Dates and duration of illness	Full names and addresses of doctors and hospitals

10. Occupation ______________________ Name of your Employer ______________________
    Are you now and have you been for the past year continuously employed on a full-time basis? yes ☐ no ☐
    If "No" give dates, duration and reasons for unemployment:

____

____

Information in this application is given to obtain insurance and is true and complete to the best of my knowledge and belief.

NO INSURANCE COVERAGE BECOMES EFFECTIVE UNTIL DATE POLICY IS ISSUED

BOSTON MUTUAL LIFE INSURANCE COMPANY

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Boston Mutual Life Insurance Company (referred to as Boston Mutual), its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my (our) application for life and/or health insurance.

Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., my employer and consumer reporting agency or insurance company who possesses information of care, treatment, or advice of me or my children my furnish such information to Boston Mutual, its reinsurers or its representatives upon presenting this authorization or a photocopy. This authorization includes information about drugs, alcoholism or mental illness.

Boston Mutual or its reinsurers may make a brief report regarding me or my children to other companies to whom I have applied or may apply.

This authorization will be valid from the date signed for a period of two and one-half years.

I authorize Boston Mutual to obtain an investigative consumer report on me.

I have read this authorization and understand I can receive a copy. I have also received copies of the "Notice Regarding MIB" and the "Notice Under The Fair Credit Reporting Act."

DATE ______________________ **SIGNATURE OF PROPOSED INSURED** ______________________

APPLICANT **MASSACHUSETTS HOSPITAL ASSOCIATION BENEFITS TRUST**

NOTIFICATION TO PROPOSED INSURED

(Parent or Guardian if a Minor)

TO BE DETACHED AND RETAINED BY PROPOSED INSURED

- -

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company, its Reinsurers, their representatives or Plan Administrators may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Report Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Mass 02112, tel. no. (617) 426-3660.

Boston Mutual Life Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.