120 Royall Street • Canton, MA 02021

1-800-669-2668 Ext. 286



STATEMENT 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.	PLEA	PLEASE COMPLETE IN FULL EMPLOYEE/EMPLOYER			IMPORTANT Submit with completed Enrollment form.		
Group # Div. #		Employer/Group Name					
Social Security #	Employ	Employee Name (Last, First, Middle Initia					
Telephone #	Address	6					
	P	ROPOSED I	INSURED(S)				
Name			tionship	Date of Birth	Height	Weight (if pregnant, pre-pregnancy weight)	
		REAS	SON				
 □ Late Applicant □ Applying for Coverage Guaranteed Amount □ Applying for Suppleme □ Other 	ental Coverage		☐ Adding ☐ Increas ☐ Adding	se in Coverage g Spouse sing Spouse g Dependent Cl			
		INSUR	ANCE				
YOU Current Insurance Additional Insurance Requested	<u>LIFE</u>	AD&D	VOLUNTAR	RY LIFE	VOLU	NTARY AD&D	
Total New Coverage							
□ Short Term Disability□ Long Term Disability	\$\\ Weekly Benefit\\$ Monthly Benefit		Other		\$		
YOUR SPOUSE	<u>LIFE</u>	AD&D	VOLUNTARY LIFE		VOLUNTARY AD&D		
Current Insurance							
Additional Insurance Requested	d						
Total New Coverage			Other		 \$		

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EVIDENCE OF INSURABILITY

		Please list all life insurance and/or annuity contacts now in-force or pending on your life							
	Existing Coverage	Name of Company (if replacement include Policy No.)	Life Amount	AD&D Amount	Year Issued or Pending	Do you intend to if you and your of insurance applie	replace or of dependents a d for on this	change this coverage are approved for the application?	ze ie
							YES	□ NO	
							YES	□ NO	
To	o be Comple	ted for ALL Proposed Insured	(s) if Requi	red by the G	roup Insuran	ce Contract			
	•	-	•	•	•		or patches) v	vithin the past 1	2
	months? **	used any form of tobacco products (cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches) within the past 12 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**	I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted only for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; G) kidney or genitourinary disease or disorder; H) disorder of the back, muscles, bones or joints; I) liver disease or disorder; J) pancreatitis (new or acute); or K) thyroid disorder?						; -		
3.		In the past 5 years, have ANY of the proposed insureds been treated for or been diagnosed by a licensed medical professional as naving an immune deficiency disorder or AIDS (Acquired Immune Deficiency Syndrome)?							
4.	I. 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?								
5.	5. Within the next 2 years, do you or your spouse: A) fly, or intend to fly, as pilot or crew member; B) race or test drive any form of vehicle; C) scubadive; D) hang glide or sky dive?								
	6. Have ANY of the proposed insured, within the past 5 years, used 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 7. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having)		
8.	In the past	memory loss?							
a	Amytrophic Lateral Sclerosis (ALS)? In the pact 5 years, have ANV of the proposed incureds been diagnosed by a licensed medical professional as having, autism?)		
	9. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having autism? YES NO 10. 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							1	
11	11. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Huntington's Chorea?)	
<u>T</u>	o be Comple	eted if Applying for Disabili	ity Insuranc	<u>ee</u>					
		of the proposed insureds curristions 2-12 answered "YES". In	, ,		(Attach additio	nal details on a si	gned and da	☐ YES ☐ Noted ted separate sheet)	C
N	ame	Medical Con	dition	Date(s)	Details/Tre	atment Na	me & Addre	ess of Attending	_
							r nysicians a	and Hospitals	_
									_
									_

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

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

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