120 Royall Street • Canton, MA 02021

1-800-669-2668 Ext. 473



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.		PLEASE COMPLETE IN FULL EMPLOYEE/EMPLOYER			IMPORTANT Submit with completed Enrollment form.		
Group # Div. #		Employer/Group Name					
Social Security #	Employ	ree Name (La	st, First, Middle Initia	1)			
Telephone #	Address	S					
	P	ROPOSED	INSURED(S)				
Name			ationship	Date of Birth	Height	Weight (if pregnant, pre-pregnancy weight,	
		REA	SON				
 □ Late Applicant □ Applying for Coverage in Excess of the Guaranteed Amount □ Applying for Supplemental Coverage □ Other 			☐ Increase in Coverage ☐ Adding Spouse ☐ Increasing Spouse ☐ Adding Dependent Child(ren) ☐ Other				
		INSU	RANCE				
YOU Current Insurance	<u>LIFE</u>	AD&D	<u>VOLUNTAR</u>	Y LIFE	VOLUNTARY AD&D		
Additional Insurance Requested Total New Coverage							
☐ Short Term Disability	\$						
☐ Long Term Disability	Weekly Benefit \$ Monthly Benefit		Other		\$		
YOUR SPOUSE	<u>LIFE</u>	AD&D VOLUNTAR		Y LIFE	VOLU	NTARY AD&D	
Current Insurance							
Additional Insurance Requested							
Total New Coverage				\$			

ICC17 GRP- EVID 9/17 220-004 ICC 9/17

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 replace or change this coverage if you and your dependents are approved for the insurance applied for on this application?	e			
						☐ YES ☐ NO				
						☐ YES ☐ NO				
To	o be Comple	ted for ALL Proposed Insured	(s) if Requi	red by the G	roup Insuran	nce Contract				
	•	-	•	•	•	co, nicotine gum or patches) within the past 12				
	months? **									
**	I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted only for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.		years, have ANY of the propos nmune deficiency disorder or A				agnosed by a licensed medical professional as drome)? \Box YES \Box NO				
4.		5 years, have ANY of the propo amination or medical test with o				had hospitalization recommended; 2) had a				
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? 2 YES 2 NO 7. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having									
8.	,	memory loss?								
_	Amytrophic Lateral Sclerosis (ALS)?									
	9. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having autism? YES INO 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 INO									
11		years, have ANY of the propon's Chorea?	osed insured	ls been diagr	nosed by a lic	censed medical professional as having ☐ YES ☐ NO				
<u>T</u>	o be Comple	eted if Applying for Disabili	ity Insuranc	<u>ce</u>						
		of the proposed insureds currestions 2-12 answered "YES". In	, ,		(Attach additio	☐ YES ☐ NC onal details on a signed and dated separate sheet))			
N	ame	Medical Con	dition	Date(s)	Details/Tre	eatment Name & Address of Attending	-			
						Physicians and Hospitals	-			
							_			
							_			

ICC17 GRP- EVID 9/17 220-004 ICC 9/17

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

ICC17 GRP- EVID 9/17 220-004 ICC 9/17