Whole Life Insurance

EMPLOYEE LIFE OPTION PLUS

BOSTON MUTUAL LIFE INSURANCE COMPANY® -1891-

FAMILY MATTERS. NO MATTER WHAT.®

TRAINING & PROCEDURES MANUAL

FOR AGENT/ENROLLERS USE ONLY

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END-95(ESO)(20/21)

335-4876 4/24

Table of Contents

CASE APPROVAL

Case Approval: To offer an employer group the Employee Life Option Plus (ELOP), prior approval must be received from the Home Office for new cases and re-enrollments. Please contact your Internal Sales Coordinator or Regional Sales Representative to help you with the process.

Employer's Agreement Exhibit 1: Must be signed by an officer of the company and submitted no later than at the time of case submission.

Advertising Material: Only advertising approved by Home Office Legal Department can be used.

NOTE: All Direct Brokers, General Agents, Agents, and Enrollers, must be licensed and appointed with Boston Mutual, prior to the solicitation of the ELOP Product. Refer to the Licensing and Contracting section of this manual, page 36.

STANDARD ELOP UNDERWRITING GUIDELINES

Standard ELOP – Employee Life Option *Plus*				
Money Purchase – Weekly Premium				
Case Size	**Employee GI**	**Spouse GI***	**Children GI**	**Grandchildren GI**
25-500	$13	$3/$5	$3	$3
501-1,000	$16	$3/$5	$3	$3
1,001-2,500	$20	$3/$5	$3	$3
2,501+	$23	$3/$5	$3	$3

No participation requirement for guaranteed issue. A minimum of 5 acceptable policies to be issued is required for billing. Total amount purchased on a Simplified Issue basis may not exceed a total of all inforce policies for an amount of $30/week for employee, $15/week for spouse, or $5/week on dependents, (children and grandchildren).

The minimum dollar purchase is$2/week for the employee and spouse, $1/week for children and grandchildren.

*Employee must purchase a minimum of $4 or $5/week for the spouse to be eligible for an equal amount of $4 or $5/week.

ELOP – Employee Life Option *Plus*				
Defined Benefit				
Case Size 25-499	Employee GI	Spouse GI	Children GI	Grandchildren GI
Age 18-55	**$50,000**	**$25,000**	**$25,000**	**$25,000**
Age 56-70*	**$25,000**	**$15,000**	**$25,000**	**$25,000**
Case Size 500+	Employee GI	Spouse GI	Children GI	Grandchildren GI
Age 18-55	**$100,000**	**$25,000**	**$25,000**	**$25,000**
Age 56-70*	**$50,000**	**$15,000**	**$25,000**	**$25,000**

When using the defined benefit option these are the maximum amounts available.

No participation requirement for guaranteed issue. A minimum of 5 acceptable policies to be issued is required for billing.

*Maximum employee/spouse age is 70.

These underwriting guidelines are subject to change. These are guidelines only and the actual offer on a case may vary from these guidelines based on home office review and approval.

INDIVIDUAL ELIGIBILITY REQUIREMENTS

Employee - The employee must be actively at work, *(at least 20 hours per week, VT requires a minimum of17.5 hours),* between ages 18 and 72, or maximum age 70 for the defined benefit option. Waiting periods will be approved on a case by case basis. Employees do not need to purchase coverage to apply for spouse or dependent coverage.

Spouse - the spouse of an employee is eligible between the ages of 18 and 72 or maximum age 70 for the defined benefit option and actively at work. A common law spouse will be considered subject to the following state guidelines:

States in which we will allow the purchase of insurance on a spouse in a common law marriage:

- Colorado
- District of Columbia
- Iowa
- Kansas
- Oklahoma
- New Hampshire
- Montana
- Rhode Island
- South Carolina
- Texas
- Utah (must be validated by a court or administrative order)

States in which we will allow the purchase of insurance on a spouse in a common law marriage if entered into prior to the date shown:

- Alabama – January 1, 2017
- Florida – January 1, 1968
- Georgia – January 1, 1997
- Idaho – January 1, 1996
- Ohio – October 10, 1991
- Pennsylvania – January 1, 2005
- South Dakota – July 1, 1959

In all other states we will no longer allow insurance on spouses in a common law marriage.

Children - must be the employees or spouses natural children, stepchildren or legally adopted children from age 15 days through age 25.

Grandchildren - must be the grandchildren of the employee or spouse ages 15 days through age 15 years. The employee must be able to attest to the medical questions pertaining to grandchildren on the application. Written permission from the child's parent is required for amounts over $3.00 or $25,000 when applying for defined benefit amount. Refer to signature requirements, (page 25), for additional information regarding written consent. MD is excluded from allowing grandparents to apply for insurance on their grandchildren at this time.

NOTE: Children under a Custody or Guardian relationship are not eligible and fiancées are not eligible. To be considered for coverage applicants must reside in the United States.

EMPLOYEE LIFE OPTION PLUS

ELOP (BASE PLAN), Form ICC20 END-95 (ESO) (9/20)

- Interest Sensitive
- Endowment at age 95
- Age is based on Age as of the Issue Date
- Product type: Unisex - Unismoke or Tobacco/No Tobacco
- Premiums level throughout policy years
- Current Interest Rate 4.25%
- Guarantee minimum interest rate 3%
- Interest Rate in Future Years:
- Durations 11-15: Base Rate + 0.50%
- Durations 16+: Base Rate + 1.00%
- Policy Fee - $24.00 per year
- Annual Flat Expense Charge - $16.50
- Surrender Charges: Based on amount per $1,000 of insurance; varies by smoking status, issue age and duration. There is no charge if the policy has been in force for a period of 20 years.

Sample Employee Brochure refer to Exhibit 3, State approvals refer to Exhibit 2

ELOP RIDERS AND UNDERWRITING RULES

PAYOR WAIVER OF PREMIUM – ***Rider Form #WPR-P (1/05)*** **-** This benefit is available on policies purchased by employees up to and including age 55. This benefit will waive all the premiums on the employee's policy, spouse and dependent policies in the event that the employee becomes totally disabled before age 60. The disability must last at least six consecutive months and meet the definitions in the policy. Coverage will cease when the insured reaches age 60 if not disabled at that time.

STRIKE WAIVER OF PREMIUM – ***Rider Form #WPR-S (1/05)*** **-** The strike waiver of premium is available on selected cases only and must be approved by the Home Office. This benefit is available on policies purchased by employees up to and including age 69. This benefit will waive all the premiums for six months on the employee's policy, spouse and dependent policies in the event of a strike, subject to the definition in the policy. Coverage will cease when the insured reaches age 70. The Strike Rider must be added to all policies within a case.

ACCIDENTAL DEATH BENEFIT – ***Rider Form #ADR-1 (3/04)*** **-** Available to all proposed insureds, ages 5 to 60. This benefit provides double the coverage should the insured die accidentally. If accidental death occurs while the insured is a fare paying passenger on a common carrier, this benefit pays an additional benefit of the basic coverage *(up to $100,000).*

CHILDREN'S TERM INSURANCE RIDER – ***Rider Form #ICC13 CTR-1 (3/13)*** **-** Available to an employee or spouse age 18-55 covering the insured's all eligible natural children, stepchildren or legally adopted children from age 15 days through age 25 and future children after 15 days old. This rider can be added to both parents' plan but cannot exceed a total of ***25 units.*** This rider becomes paid-up until age 26 if the insured parent dies prior to the child's 26th birthday.

A child ages 21-26 may convert to a permanent policy of up to five times the benefit amount, to a maximum of $25,000 without evidence of insurability.

LEVEL TERM TO AGE 65 RIDER – ***Rider Form #ICC13 LTR-65 (3/13)E and ICC13 LTD-65 (3/13)Y*** **-** Available to an employee and his/her spouse between the ages of 18 and 55. This rider provides a level death benefit and expires on the anniversary of the date of issue on or next following the insured's 65th birthday. The Waiver of Premium benefit must also be purchased on this rider if it was purchased on the base ELOP plan. This Level Term Rider may be converted to a permanent policy at any time prior to the insured's 60th birthday. Available in increments of $.50 with a minimum purchase of $1.00 and a maximum of $3.50.

NOTE: Each $.50 purchase counts as $1.00 of Guarantee Issue used.

Riders may not be available in all states please refer to Exhibit 2.

CATASTROPHIC LOSS RIDER

Product Information
The Catastrophic Loss Rider (CATLOSS-Rider 8/09) is simplistic in design. It provides benefits *(after the elimination period has been satisfied)* for a loss of 2 or more Activities of Daily Living (ADLs) provided the individual is under the regular care and attendance of a physician. ADL's include bathing, dressing, toileting, eating, transferring and continence. Unlike Long Term Care insurance, there is no requirement that the individual be confined in a nursing home or receiving home health care.

- Monthly benefit options: $1,000, $2,000 or $3,000
- **Maximum benefit period options:** 12 months, 24 months or 36 months
- Elimination period options: 90 days or 180 days

You can use both elimination periods in a case if you so desire or this decision can be made at the case level.

Waiver of Premium
If the Payor Waiver Rider is purchased, the premiums for this Rider will also be waived under the same terms as the ELOP coverage. The Catastrophic Loss Rider premium will be added to the base premium when calculating the 10% for the Payor Waiver.

Limitations and Exclusions

Pre-Existing Conditions Limitations
Benefits will not be payable for any pre-existing conditions during the first six (6) months this coverage is in force. A **Pre-Existing Condition** means an Injury or Sickness for which, during a six-month period immediately preceding the Effective Date of this coverage, the insured has 1) received a diagnosis or advice from a Physician; 2) received treatment; 3) incurred medical expenses; or 4) taken prescription drugs.
Diagnosis must occur after the Rider is in force.

Exclusions
This benefit is not payable for any Catastrophic Loss which is due to 1) an intentionally self-inflicted injury while sane or insane; 2) active participation in a riot; 3) commission of a felony; 4) war, declared or undeclared or any act of war, while serving in the military or any auxiliary unit thereto; 5) a Pre-Existing Condition, except as provided for under the Pre-Existing Condition Limitation; 6) the voluntary use of alcohol or any controlled substance *(as defined in Title II of the Comprehensive Drug Abuse and Prevention and Control Act of 1970 and all amendments)* unless prescribed by a Physician. No benefits are payable during any period in which the insured is incarcerated. In addition, no benefits are payable to the insured for any period of thirty (30) or more consecutive days during which the insured is outside of the United States, its territories or possessions, Canada or Mexico.

Exclusions vary slightly in the states of AL, DC & SD. Please refer to the Rider for specific policy language. **This Rider is not a Long-Term Care or Disability Income Product.**

Eligibility
This rider is available to employees and their spouses ages 18-70 and applying for our ELOP life insurance coverage. This Rider cannot be added to existing ELOP Life insurance policies; however, an employee or spouse can purchase additional ELOP Life insurance coverage and include this rider. **If the employee and/or spouse have reached his/her maximum GI Issue limit for the ELOP coverage they can apply on a simplified basis subject to plan maximum.**

Rates
The rates are Unismoke. There is no tobacco distinction for this rider but it can be used with both the unismoke and tobacco/non-tobacco ELOP life insurance base policy coverage. There are two rate schedules – the applicable rate schedule decision is made at the Case level.

- **Case Level Rates** – these rates are to be used when all employees and spouses who are eligible and purchase the ELOP life coverage **must** also purchase the Catastrophic Loss Rider.
- **Optional Rates** – these rates are to be used when the employee and spouse will have a choice whether to apply for the Rider or not.

Brochure & Rate Sheets
Brochure – can be used with either set of rate sheets. This brochure is one page, double-sided:

- "Case Level" Rate Sheets:
  - 90 Day Elimination Period
  - 180 Day Elimination Period
- "Optional" Rate Sheets
  - 90 Day Elimination Period
  - 180 Day Elimination Period

MA and UT have state specific brochures and rates. Contact Sales Operations for assistance with materials.

Completing the Application
You will use the same application you use for the ELOP life insurance coverage. Under the "Additional Benefits" section of the application, there is a field labeled "Other". Once you've selected the coverage level using the rate sheets, simply write the corresponding Application Code in the Other Field and indicate the monthly benefit amount in the Amount Column. Please see the underwriting table on the following page for the appropriate code for each level of benefit and the limits based on the face amount of the total ELOP coverage.

Underwriting
The same underwriting rules apply for the CATLOSS Rider as the base life insurance coverage.

Appointment/Licensing
Since this is a health rider and not a traditional Long Term Care Rider, there is no LTC continuing education or special licensing required.

Coverage Amounts
The amount of coverage an individual can purchase is determined based on the face amount of the ELOP life insurance coverage currently applied for combined with any existing ELOP life insurance coverage already in force. For our electronic enrollment system, we will automatically include information on the existing ELOP life insurance coverage in force. For paper enrollments, we can provide you with a report showing in force ELOP life insurance coverage for each case you are enrolling.

CATASTROPHIC LOSS RIDER – UNDERWRITING CHART

The minimum face amount of ELOP Life insurance is $8,000 to be eligible for this rider. If Case Level rates are used, individuals with ELOP face amounts less than $8,000 may still purchase the ELOP coverage but not this rider.

Individuals with an ELOP total face amount from $8,000 up to $10,000 are eligible to purchase one of the following:				
Elimination Period (Days)	**Monthly Benefit Amount**	**Benefit Period**	**Case Level Rates Application Code**	**Optional Rates Application Code**
90	$1,000	12 months	CL1	CE1
180	$1,000	12 months	CL6	CE6

Individuals with an ELOP total face amount up to $15,000 are eligible to purchase one of the following:				
Elimination Period (Days)	**Monthly Benefit Amount**	**Benefit Period**	**Case Level Rates Application Code**	**Optional Rates Application Code**
90	$1,000 or $2,000	12 months	CL1	CE1
180	$1,000 or $2,000	12 months	CL6	CE6
90	$1,000	24 months	CL2	CE2
180	$1,000	24 months	CL7	CE7

Individuals with an ELOP total face amount up to $20,000 are eligible to purchase one of the following:				
Elimination Period (Days)	**Monthly Benefit Amount**	**Benefit Period**	**Case Level Rates Application Code**	**Optional Rates Application Code**
90	$1,000, $2,000 or $3,000	12 months	CL1	CE1
180	$1,000, $2,000 or $3,000	12 months	CL6	CE6
90	$1,000	24 months	CL2	CE2
180	$1,000	24 months	CL7	CE7
90	$1,000	36 months	CL3	CE3
180	$1,000	36 months	CL8	CE8

Individuals with an ELOP total face amount up to $30,000 are eligible to purchase one of the following:				
Elimination Period (Days)	**Monthly Benefit Amount**	**Benefit Period**	**Case Level Rates Application Code**	**Optional Rates Application Code**
90	$1,000, $2,000 or $3,000	12 months	CL1	CE1
180	$1,000, $2,000 or $3,000	12 months	CL6	CE6
90	$1,000 or $2,000	24 months	CL2	CE2
180	$1,000 or $2,000	24 months	CL7	CE7
90	$1,000	36 months	CL3	CE3
180	$1,000	36 months	CL8	CE8

Individuals with an ELOP total face amount up to $50,000 are eligible to purchase one of the following:				
Elimination Period (Days)	**Monthly Benefit Amount**	**Benefit Period**	**Case Level Rates Application Code**	**Optional Rates Application Code**
90	$1,000, $2,000 or $3,000	12 months	CL1	CE1
180	$1,000, $2,000 or $3,000	12 months	CL6	CE6
90	$1,000, $2,000 or $3,000	24 months	CL2	CE2
180	$1,000, $2,000 or $3,000	24 months	CL7	CE7
90	$1,000 or $2,000	36 months	CL3	CE3
180	$1,000 or $2,000	36 months	CL8	CE8

Individuals with an ELOP total face amount over $50,000 or more are eligible to purchase one of the following:				
Elimination Period (Days)	**Monthly Benefit Amount**	**Benefit Period**	**Case Level Rates Application Code**	**Optional Rates Application Code**
90	$1,000, $2,000 or $3,000	12 months	CL1	CE1
180	$1,000, $2,000 or $3,000	12 months	CL6	CE6
90	$1,000, $2,000 or $3,000	24 months	CL2	CE2
180	$1,000, $2,000 or $3,000	24 months	CL7	CE7
90	$1,000, $2,000 or $3,000	36 months	CL3	CE3
180	$1,000, $2,000 or $3,000	36 months	CL8	CE8

UNDERWRITING GUIDELINES

This section outlines guidelines to assist in field underwriting. ***These are only*** guidelines and they should help eliminate an application on a proposed insured who does not qualify due to a medical impairment.

The underwriting decision on simplified applications is normally based upon information provided on the application and health questionnaire. They will be handled on an accept or reject basis. However, Boston Mutual will allow employees who are reduced to Guarantee Issue or declined the option of obtaining their medical records from their personal physician within 30 days of the issue date at no cost to Boston Mutual. Upon receipt Boston Mutual will review to determine if eligible.

When an employee and spouse both work for the same company, they are both eligible to purchase a policy for the employee, spouse and children's guarantee issue amount.

Example: Karen and Fred work for the same Company with a Guarantee Issue of $13/3/3/3 per week. Karen may purchase a policy for herself for $13/week for Guarantee Issue and a policy for Fred for $3/week for Guarantee Issue. Fred may purchase a policy for himself for $13/week and a policy for Karen for $3/week for Guarantee Issue. This will give a total amount of $16/week Guarantee Issue for each employee. In regard to the children, the same rule will apply. Both parents may purchase a Guarantee Issue policy giving a total Guarantee Issue of $6/week. In NO case can the simplified issue amount be exceeded.

When an employee works for ABC Company and purchases a policy, and then moves to another company which also offers the ELOP product and the policy is still premium-paying, we will add the purchased amount to determine the maximum Guarantee Issue or Simplified Issue limit.

ADULT MAXIMUM HEIGHT AND WEIGHT CHART

This chart has been established as a guideline for the minimum and maximum height and weight for those individuals applying for Simplified Issue.

Please limit the proposed insured outside these guidelines to the Guarantee Issue amount only. This will eliminate any delays at the time of issue or deduction changes.

	HEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT
Height			
4 FT.	8”	74	167
	9”	76	173
	10”	79	179
	11”	82	185
5 FT.	0”	84	192
	1”	87	198
	2”	90	205
	3”	93	212
	4”	96	218
	5”	99	225
	6”	102	232
	7”	105	239
	8”	109	246
	9”	112	253
	10”	115	261
	11”	118	268
6 FT.	0”	122	276
	1”	125	284
	2”	129	292
	3”	132	300
	4”	136	308
	5”	139	316
	6”	143	324
	7”	150	332
	8”	157	341
	9”	162	349

CHILD MAXIMUM HEIGHT AND WEIGHT CHART

HEIGHT AND WEIGHT OF INFANTS											
	Age in Months										
	1	2	3	4	5	6-8	9-11	12-14	15-17	18-20	21-24
	Weight in Pounds										
Min. Wt	5	6	8	9	10	11	13	14	16	18	19
Av. Wt.	8	10	13	15	16	18	19	22	23	24	27
Max. Wt.	14	17	20	22	25	29	32	35	38	44	50
	Height in Inches										
Min. Wt	19	20	21	22	23	23	24	26	27	28	29
Min. Wt	20	22	24	25	26	27	28	30	31	32	34
Min. Wt	24	26	28	29	31	33	35	37	38	40	42

HEIGHT AND WEIGHT OF CHILDREN							
AGES 2-4 – WEIGHT				AGES 5-8 – WEIGHT			
HEIGHT	MIN	MAX	INCHES	HEIGHT	MIN	MAX	INCHES
2 FT				3 FT			
6”	19	45	30	2”	27	65	38
7”	19	47	31	3”	29	68	39
8”	20	49	32	4”	30	72	40
9”	20	51	33	5”	32	75	41
10”	21	53	34	6”	34	79	42
11”	22	56	35	7”	36	82	43
3 FT				3 FT			
0”	24	59	36	8”	38	86	44
1”	25	62	37	9”	40	89	46
2”	26	64	38	10”	42	93	46
3”	27	67	39	11”	44	96	47
3 FT				4 FT			
4”	29	70	40	0”	46	100	48
5”	30	73	41	1”	48	103	49
6”	31	75	42	3”	50	107	50
7”	32	77	43	4”	54	114	52
				5”	56	117	53
				6”	58	121	54
				7”	60	124	55
				8”	62	128	56

AGES 9-11 – WEIGHT			
HEIGHT	**MIN**	**MAX**	**INCHES**
3 FT			
8”	35	83	44
9”	37	87	45
10”	40	91	46
11”	42	95	47
4 FT			
0”	45	100	48
1”	47	104	49
2”	50	108	50
3”	52	112	51
4 FT			
4”	55	116	52
5”	57	121	53
6”	60	125	54
7”	62	129	55
4 FT			
8”	65	133	56
9”	67	137	57
10”	70	142	58
11”	72	146	59
5 FT			
0”	75	150	60
1”	77	155	61
2”	80	160	62
3”	83	166	63

AGES 12-14 – WEIGHT			
HEIGHT	**MIN**	**MAX**	**INCHES**
4 FT			
4”	54	122	52
5”	57	127	53
6”	60	133	54
7”	63	138	55
4 FT			
8”	66	144	56
9”	69	149	57
10”	72	155	58
11”	75	160	59
5 FT			
0”	78	166	60
1”	81	171	61
2”	84	177	62
3”	87	182	63
5 FT			
4”	91	188	64
5”	94	193	65
6”	97	199	66
7”	100	204	67
5 FT			
8”	103	210	68
9”	106	215	69
10”	109	221	70
11”	113	226	71

UNINSURABLE MEDICAL IMPAIRMENTS FOR LIFE INSURANCE

This is a partial list of medical impairments that our underwriters feel are outside the standard table for which our life product is approved. When an individual has or has had the following medical conditions, please limit a proposed insured to the maximum Guarantee Issue amount. This will eliminate any delays at the time of issue or deduction changes.

- Diabetes - Insulin dependent diabetes or combination of diabetes and other medical condition
- Heart - History of heart attack or bypass surgery in the past 10 years
- Epilepsy - Last attack within one (1) year or frequent episodes
- Ulcers - If treated surgically within 2 years
- Cancer, leukemia, Hodgkin's, breast or melanoma within 7 years
- Kidney Stones - Under treatment
- Amyotrophic Lateral Sclerosis (ALS) – Active
- Huntington's chorea - Active
- Alcohol or drug abuse within 5 years
- Emphysema - Severe and under treatment
- AIDS - Includes ARC (AIDS Related Complex)
- Liver - Any impairments other than acute hepatitis
- Multiple Sclerosis - Last attack within 5 years
- Nervous Disorder - Hospitalized within 5 years
- Chronic renal *(kidney)* failure
- Stroke

SAMPLE OF ADDITIONAL HEALTH INFORMATION

The following underwriting details are required to be completed on Part B of the application:

Additional Details for Asthma

1. Frequency of attacks and date of last attack: Frequency _____ Number _____
2. Is the condition: Mild ☐ Moderate ☐ Severe ☐
3. Is it: Seasonal or Perennial Asthma? _____
4. Type of Treatment required: _____
5. How much time is lost from work/school due to Asthma? _____

Additional Details for High Blood Pressure

1. What type of treatment are you receiving for high blood pressure? _____
2. List blood pressure readings and date:

Readings	Date
_____	_____
_____	_____

3. Do you have any other complications from high blood pressure? _____

Additional Details for Ulcer

1. What type of treatment did you receive and on what date? _____
2. Have you ever had a hemorrhage or an operation for the ulcer? Yes ☐ No ☐

Additional Details for Diabetes

1. How long have you had Diabetes? _____
2. What type of treatment are you taking? _____
3. Do you have any complications from Diabetes? _____
4. What was your last Blood Sugar reading? _____

Additional Details for Epilepsy

1. Date of first and last seizure? _____
2. What type of seizure disorder: _____

SAMPLE OF ADDITIONAL HEALTH INFORMATION

The following underwriting details are required to be completed on Part B of the application:

Additional details for aviation

1. Number of hours flown as a pilot, co-pilot, crew member or student pilot: _____
2. Annual flying hours: _____
3. Total hours experience: _____
4.

Additional details for racing

1. Type of vehicle used: _____
2. Are you presently participating? _____
3. Date of last event: _____

Additional details for skin/scuba diving

1. How long have you been scuba diving?_____
2. How often in the last year? _____
3. Greatest depth:

Additional details for hang gliding/sky diving

1. How long have you been skydiving? _____
2. How often in the last year? _____
3. Total number of jumps made: _____

Additional Details for Drugs

1. What type of drugs did you use in the past 5 years and date last used? _____

Additional Details for Alcohol

1. How often do you drink alcoholic beverages? _____
2. Have you ever been arrested for driving while under the influence of alcohol, or treated for alcoholism? Please give details with dates: _____
3. Date of last alcohol consumption: _____

ELOP LIFE APPLICATION

The Life application, (Exhibit 4), is designed to be used for all family members applying for coverage.

Information on the employee is required on all applications even though he/she may not be applying for insurance, as they are the payor and owner in most cases. The following information must be completed at all times:
Name, Address, SS#, Question # 9, Employer and DOB, (DOB is only required if payor wavier is requested)

If the application is within the Guarantee amount, the front page of the application must be completed. If you are taking an application that requires Simplified Issue, height, weight and medical questions must also be completed on the reverse side of the application.

Accurate applications are essential for the prompt issue of the policy and for paying commissions. Applications with "white-out" will not be accepted. All changes must be initialed by the employee. Errors may require further investigation by the Case Coordinator.

The effective date of coverage is the date of the application, provided that the Company approves the application without any modification as to plan or premium and further, receives the first premium payment from the employer within 90 days of the application date. Free coverage is provided from the date of the application to the policy effective date, normally not to exceed 90 days.

The following are USA PATRIOT Act guidelines to follow when enrolling ELOP
Customer Identification:

- Each individual enrollee/owner of the ELOP policy or policies, in the event of spouse coverage for example, must supply an SSN or an ITIN for the application.
- If the individual uses an ITIN and the coverage being offered is greater than $50,000 the agent must review the customer's unexpired, government issued picture ID and complete the Customer Verification Form (CUSID1106)
- An acceptable government issued picture ID includes – Green Cards (permanent residency cards), Driver's License or Passport. In these instances, if the application is not submitted with a completed Customer Verification form, the policy cannot be issued.

Customer Address:

- Each ELOP application must display the RESIDENTIAL address of the insured and the owner. Coverage cannot be issued without a residential address. For mailing purposes, a P.O. Box may be added in the optional Communication field.

Notification:

- The "USA PATRIOT Act Notification" is located on the back of the "NOTICE OF INFORMATION PRIVACY PRACTICES", (Exhibit 6), which is given out at the time of enrollment.

INSTRUCTIONS FOR THE COMPLETION OF THE ELOP APPLICATION (form #335-3983)

PART A: (State variations apply in CA, DE, DC, FL, ND and SD)

1. Proposed Insured Employee/Owner Name: always required
2. Gender: only required if employee is applying for insurance
3. Date of birth: only required if employee is applying for insurance or payor waiver on dependents.
4. Issue age: Age as of the issue date, only required if employee is applying for insurance.
5. Employee social security number: always required.
6. Telephone number: Home phone or cell phone - always required.
7. Present residence (Address): always required. using only a P.O. Box as the address is unacceptable. Additional box for PO Box/Communication Address is available if needed.
8. Employee Occupation: optional
9. Are you actively at work is always required: If no, the employee is not eligible to participate in the plan.
10. Employer name: always required
11. Date of employment: always required
12. Amount of insurance only required if employee is applying for insurance: Face amount being applied for.
13. Employee's premium: Payment mode of deduction, always required if applying for insurance.
14. Automatic Premium Loan on all policies included on this application? Check Yes. Always required.
15. Additional Benefits: Check appropriate box to add additional benefits: Waiver of Premium, Accidental Death Benefit, Children's Insurance Benefit Rider and/or Level Term to age 65.
    - To add CAT rider enter appropriate code in other box. The amount column is required for CIB, LT-65 and other if CAT rider is requested.
    - The premium column must be completed for all benefits.
16. Beneficiary: Name and Relationship of Primary and Contingent Beneficiary are required.
    - Address, telephone#, SS# and DOB are optional.
17. Proposed insured (Spouse): Name of Proposed Insured Spouse, only required if spouse is applying for insurance.
18. Gender: only required if spouse is applying for insurance.
19. Date of birth: only required if spouse is applying for insurance.
20. Issue Age only required if spouse is applying for insurance: Age as of issue date.
21. Telephone number: Home phone or cell phone number: optional

22. Present Residence (Same as Employee): Yes or No. If no, details must be given in remarks section #30.

23. Are you actively at work? ( ) Yes ( ) No

    - **CURRENTLY UNDERWRITING IS NOT REQUIRING THIS QUESTION TO BE COMPLETED AS OF January, 2021.**
    - If NO, reason/details should be provided in the remarks section #30 on the application.
    - The spouse can be retired or a housewife or a househusband; this is considered a full time job.
    - There will be situation where the answer is NO and it will indicate in the remarks section that a proposed insured spouse is in a nursing home or hospital. In those situations we will require the proposed insured to be able to perform the Activities of Daily Living as follows:
        i. Eating
        ii. Bathing
        iii. Dressing
        iv. Toileting (being able to get on and off the toilet and perform personal hygiene functions)
        v. Transferring (being able to get in and out of bed or a chair without assistance)
        vi. Maintaining continence (being able to control bladder and bowel)

24. Amount of Insurance: Face amount being applied for – only required if spouse is applying for insurance.

25. Spouse's premium: Payment mode of deduction is only required if spouse is applying for insurance.

26. Additional Benefits: Check appropriate box to add additional benefits: Waiver of Premium, (WOP is based upon the Employee and is referred to Payor Waiver), Accidental Death Benefit, Children's Insurance Benefit Rider and/or Level Term to age 65.
    - To add CAT rider enter appropriate code in other box.
    - The amount column is required for CIB, LT-65 and other if CAT rider is requested.
    - The premium column must be completed for all benefits.

27. Total Premium: Enter total premium for Employee, Spouse, and Children: (Including Riders).

28. Beneficiary: Name and Relationship of Primary and Contingent Beneficiary are required if Spouse is applying for coverage. Address, telephone#, SS# and DOB is optional

29. Have any of the proposed insured's used any tobacco or nicotine products in the past twelve months? Complete only for smoker/non-smoker policy for the employee and/or spouse. This includes e-cigarettes, nicotine patches, cigars and pipes.

30. Remarks: Use this section for details of #22 and #23.

31. Employee is the Beneficiary of the children if living, otherwise the employee's estate.

32. Proposed Additional Insured(s) *(Children and/or Grandchildren)*: In all cases when applying for an individual policyor the children's term rider, complete name, date of birth, issue age, gender and relationship to the applicant.
    - Children's Term Rider: Enter amount of insurance $1,000- $25,000 in question #15 or #26 (amount of children's insurance benefit).
    - Permanent Insurance: Enter in the mode premium amount $1-$5, face amount and ADB or PW if requested. (If Payor Waiver is added employee information must be completed).

- Smoker question must be completed on all children applying for an individual policy 18+ years.

33. Has the Applicant any existing life insurance policies in force for any proposed insured? This includes all other companies and Boston Mutual policies which have lapsed or been cancelled within the last 13 months.

34. If answered Yes, the Notice of Replacement must be completed.
    - Answer Yes or No if the Applicant intends to replace existing policies on any proposed insured: If Yes, give the name of the company, policy number being replaced and complete all required state replacement forms.

PART B: (State variations may apply to the medical questions)

35. Name, Relationship to the employee, height and weight of the proposed insured must be completed on anyone applying for a Simplified Issue Amount.

36. A-E, 37 – 40. Health questions apply to all proposed insured's applying for a Simplified Issue Amount

36. In the past 5 years have any of the proposed insured been diagnosed by a member of the medical profession with:

A. (1) asthma, emphysema or COPD (chronic obstructive pulmonary disease or disorder); (2) high blood pressure, stroke, heart or circulatory disease or disorder; (3) intestinal disease or disorder or ulcer; (NOTE: Diabetes has been removed and is now a separate question #36B)(4) leukemia, cancer, tumor or malignancy; (5) epilepsy, mental or nervous disease or disorder; (6) kidney or genito-urinary disease or disorder; (7) liver disease; (8) pancreatitis(new or acute); (9) thyroid disorder; (10) transient ischemic attack (TIA) or (11) disorder of the back, muscles, bones or joints?

B. (1) diabetes requiring insulin, been prescribed or used insulin for the treatment of diabetes, or been diagnosed with or treated for complications of diabetes, including Insulin Shock, Diabetic Coma, Retinopathy, Neuropathy, Amputation, Nephropathy, Kidney disorder or End stage renal disease?

C. (1) having Amyotrophic Lateral Sclerosis (ALS)?

D. (1) having Huntington's chorea?

E. (1) having Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS)?

37. In the past 5 years have any of the proposed insured (1) been hospitalized or had hospitalization recommended; (2) had a physical examination or medical test with other than normal results?

38. In the past 5 years have any of the proposed insured used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, opioids or other habit forming drugs, except as prescribed by a member of the medical profession?

39. In the past 5 years have any of the proposed insured received medical treatment or counseling for, or been advised by a member of the medical profession to discontinue, the use of alcohol or prescribed or non-prescribed drugs?

40. Do any of the proposed insureds: (1) fly, or intend to fly, within the next 2 years, as a pilot or crew member; (2) race or test any form of vehicle; (3) skin or scuba dive; (4) hang glide or sky dive?

41. Details for questions 36 through 40 answered "YES". Include question number. An additional sheet of paper may be used if additional space is required.

- Name…..Disease or Injury…Date Diagnosed…….Details – include treatment & medication

- Agreement and Declaration Section: The employee must read this section before signing the application.

- Signature Section: The signature of the employee is always required. The signature of the spouse and/or dependent if required by State law.

- Agents Statement: must always be answered yes or no. If yes, the appropriate replacement forms must be completed.

- Witness of the application question is by a licensed agent. Signed at State (State where application is being completed) is also required and date of signature.

- Replacement Notice: (2 pages), must be complete when the replacement question is answered Yes.

- MIB Pre-Notice and Authorization: The signature of the employee is only required when the amount of insurance is over the guarantee issue amount.

- Authorization for Release of Health Related Information: The signature of the employee is only required when the amount of insurance is over the guarantee issue amount.

- Note: The questions shown here are the questions for the standard application and there are slight variations to the application wording in some states.

SUBJECT: Agents licensed to write business in Pennsylvania

In accordance with the State of Pennsylvania Regulation Title 31 Pa. Code 83.3, a Disclosure Statement must be completed and given to the applicant for all proposed insureds at the time of application. The ELOP rate sheet has been updated to include the Guaranteed Cash Values for 5, 10, 20 years and age 65 based upon face amount and issue age.

Although you are not required to submit a copy of the disclosure with the application, you must complete the “Life Insurance Disclosure Certification” and submit a listing of all proposed insureds who received the completed disclosure. The certification and listing must be submitted to the Home Office along with the applications.

APPLICATION STATE VARIATIONS

ELOP FORM #335-3983

State	Application 335-3983 Variation	Application 335-3983 Generic	Application ICC 335-3983 Compact STD	Application Approved	VARIATION DESCRIPTION
AK			12/31/2018	Y	
AL			12/31/2018	Y	
AR			12/31/2018	Y	
AZ			12/31/2018	Y	
CA	5/29/2019			Y	Added page numbers, removed fraud warning and added section G to the agreement section, authorization wording change from standard, changes made to MIB authorization and medical question revised to comply with CA adding Section #41.
CO			12/31/2018	Y	
CT			12/31/2018	Y	
DC	5/22/2019			Y	Changed Fraud Warning to read = 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. Date on form number remained the same, but the form was re-filed to add the word "payor" to the spouse rider section.
DE		5/17/2019		Y	Removed Fraud Warning and the time limit on the MIB authorization the time is limited to 24 months. - Form #335-3983 Generic
FL	6/5/2019			Y	Reworded replacement question #34, medical questions reworded and reformatted, #36 was added as a separate question for HIV. Date on form number was changed to ELOP FL 5/19 and 335- 3983 5/19 due to a re-file to add the word "payor" to the spouse rider section.
GA			12/31/2018	Y	
HI			12/31/2018	Y	
IA			12/31/2018	Y	
ID			12/31/2018	Y	
IL			12/31/2018	Y	
IN			12/31/2018	Y	
KS			12/31/2018	Y	
KY			12/31/2018	Y	
LA			12/31/2018	Y	
MA			12/31/2018	Y	
MD			12/31/2018	Y	

ME			12/31/2018	Y	
MI			12/31/2018	Y	
MN			12/31/2018	Y	
MO			12/31/2018	Y	
MS			12/31/2018	Y	
MT			12/31/2018	Y	
NC			12/31/2018	Y	
ND		5/24/2019		Y	Removed Fraud Warning and the time limit on the MIB authorization the time is limited to 24 months. - Form #335-3983 Generic. Date on form number remained the same, but the form was re-filed to add the word "payor" to the spouse rider section.
NE			12/31/2018	Y	
NH			12/31/2018	Y	
NJ			12/31/2018	Y	
NM			12/31/2018	Y	
NV			12/31/2018	Y	
OH			12/31/2018	Y	
OK			12/31/2018	Y	
OR			12/31/2018	Y	
PA			12/31/2018	Y	
PR			12/31/2018	Y	
RI			12/31/2018	Y	
SC			12/31/2018	Y	
SD		5/21/2019		Y	Removed Fraud Warning and the time limit on the MIB authorization the time is limited to 24 months. - Form #335-3983 Generic. Date on form number remained the same, but the form was re-filed to add the word "payor" to the spouse rider section.
TN			12/31/2018	Y	
TX			12/31/2018	Y	
UT			12/31/2018	Y	
VA			12/31/2018	Y	
VT			12/31/2018	Y	
WA			12/31/2018	Y	
WI			12/31/2018	Y	
WV			12/31/2018	Y	
WY			12/31/2018	Y	

MISCELLANEOUS STATE VARIATIONS

State	Disclosure	Buyers Guide Required at time of Sale, (as of 12/14)	Secondary address option, (as of 5/16)
Alabama	ABOR Disc		
Alaska			
Arizona			
Arkansas	ABOR Disc		
California	Requires Disclosure form for Life Sales to individuals age 65 and over. Form # CAL-EDISC 3/11 is to be given out at time of application. No signature or copy is required. This is required for both General Agencies and the Worksite sales.		Yes
Colorado			
Connecticut			Yes
Delaware			
District of Columbia			
Florida			Yes
Georgia		Form #230-055 06/16	
Hawaii			
Idaho			Yes
Illinois	ABOR Disc	Form #230-054 06/16	
Indiana	ABOR Disc		
Iowa			
Kansas	ABOR Disc		
Kentucky			
Louisiana	ABOR Disc		
Maine		Form #230-067 06/16	Yes
Maryland			
Massachusetts	CAT Rider requires signed disclosure at point of sale. Form number CATLOSS-ACC-Rider 01/10 (DiscAppl) MA. ABOR Disc		
Michigan	ABOR Disc		
Minnesota	Applicants over age 65 a copy of the application and form MN-DISC must be given at time of application. ABOR Disc		
Mississippi	ABOR Disc		
Missouri			
Montana	ABOR Disc		
Nebraska	ABOR Disc		
Nevada			
New			

Hampshire			
New Jersey			
New Mexico			
North Carolina	ABOR Disc		
North Dakota			
Ohio	ABOR Disc		
Oklahoma	ABOR Disc		
Oregon	ABOR Disc		
Pennsylvania	SPECIAL DISCLOSURE - FORM NUMBER PA WS DISCLOSURE 05 ABOR Disc		
Puerto Rico	ABOR Disc		
Rhode Island			
South Carolina			
South Dakota			
Tennessee			
Texas			
Utah			Yes
Vermont			Yes
Virginia	ABOR Disc		
Washington	Requires a juvenile affidavit, form number, WA-Juvenile 6/09 to be completed on all children under age 18 for an individual policy and/or children's rider ABOR Disc	Form # 230-054 6/16	
West Virginia			
Wisconsin			
Wyoming			

SIGNATURE REQUIREMENTS (AS OF 1/3/18)

In some states, consent is required for an employee to purchase life insurance on his or her spouse and/or children. To avoid sending the application home with the employee, we have designed a spouse/dependent consent form (Exhibit 5), which assures Boston Mutual that the spouse or child has consented to being insured. This form must accompany the applications or be sent to the Home Office prior to release of the policy.

THE FOLLOWING STATES REQUIRE CONSENT:

California – Requires spousal consent for amounts over $50,000.

Massachusetts – Parents or legal custodian can purchase life insurance on the life of a minor under age 15. For a grandparent to purchase insurance on a child under age 15 we will need the consent of the parent, guardian or legal custodian. At age 15 and older we will need the consent of the proposed insured. Spousal consent is also required.

Michigan – Any individual who has an insurable interest on the life of another shall not insure that person without their consent. This applies to life insurance policies of $10,000 or more. This does not apply to a proposed insured less than 18 years of age.

Missouri – Requires spousal consent and consent for children 18 and older. **Pennsylvania –** Requires spousal consent and consent for children 18 and older. **South Carolina –** Requires spousal consent.

Washington – Requires spousal consent and grandchildren require parental consent. When adding a child or ADB rider for children under the age of 18, the WA Juvenile Affidavit must be completed. For children 15 or older, the child must sign the WA Juvenile Affidavit.

All other states do not require spousal consent.

Consent is required in ALL STATES for common law spouses if applicable.

See eligibility guidelines on page 5. Parental consent is required on all grandchildren applications over $3/week or defined benefit over $25,000.

The agent/enroller completing the application must sign as licensed agent. All agents/enrollers must be licensed and appointed with Boston Mutual prior to solicitation of any insurance products.

Signature and date on the bottom of the applications are required. The employee is the owner and payor of all policies unless otherwise indicated.

The signature of the spouse and/or dependent may be required depending upon the state the application is being signed in.

NOTICE OF INFORMATION PRIVACY PRACTICES

The Boston Mutual NOTICE OF INFORMATION PRIVACY PRACTICES (Exhibit 6) must be given to all employees applying for insurance at the time the application is being taken. The only exception occurs on telephonic sales if the interviewed employee agrees that the notice will be provided at policy delivery.

Enroller Practices for Customer Privacy During Enrollments:

During the enrollment process, special care must be taken by the enroller to ensure that the confidential personal information the customer is giving cannot be overheard by any other employee or individual.

If you are offered a room to enroll customers in, be sure that only one customer at a time is present in the room with you.

- If you are not offered a private room at the facility at which you are enrolling, please:
- Keep other customers at a distance from the individual you are enrolling; Speak softly and ask the customer to please speak softly as well, to protect their private information;
- Remember - never discuss insurance with a customer in a public space. If you are approached in a public space by a customer with a question or comment that may involve personal information or private health information, explain to the individual that to protect their privacy you can only speak with them in a private area.

Privacy and Security Program for Laptop Computers and Other Electronic Portable Devices:

Laptop computers and other electronic portable devices are commonly used in conducting our business for many reasons including, for example, electronic enrollment, sales presentations and census data for sales purposes. *We* must comply with all applicable laws designed to protect that information from theft and unlawful exposure.

- Laptops used to review, store or transport any Personally Identifiable Information (PII) and/or Protected Health information (PHI) of a Boston Mutual customer, or any information related in any way to Boston Mutual Life Insurance Company business, which is not on encrypted software, must be encrypted.

- No one should have any PII or PHI of a Boston Mutual customer stored on any portable electronic device, PDA, USB drive, I-pod, for example, unless you have company approval and have signed a form with the company approving this usage. If you have authorization to store data, the portable electronic device must be protected to the extent that it is technically feasible.

- If you are not authorized to store information, but you are accessing information, such as e-mail, and the electronic portable device you are using is lost or stolen you must contact the service provider to have the service provider de- activate the service and immediately change your password.

- If your laptop or other electronic portable device is ever stolen and you believe that there is any possibility that the PII or PHI of any customer has been compromised, it must be immediately reported to the Privacy Officer of Boston Mutual Life Insurance Company (telephone number 781-770-0422). There can be very serious fines and penalties for not reporting security breaches.

- In addition to the items listed above you are expected to further protect the laptop or portable electronic device as follows. Laptops and portable electronic devices must:

Never be left on if unattended;

- Always be secured when not in use;
- Never be used in a manner or in a place where others can view the information on the screen;
- Never be left in a parked car. If it must be left in the car it must be locked in the trunk or other storage compartment and out of view;
- Never be checked in or with your luggage;
- Always be stored during a hotel stay in a safe and secure space and locked.
- Have information cleaned off the device once the data is used or transferred and is no longer required.

RE-ENROLLMENT GUIDELINES

Newly eligible individuals may apply for coverage on a Guarantee Issue basis in accordance with the issue limits established for the case. Spouses and children who are **newly** eligible are included in this rule, regardless of whether the employee previously waived coverage. Individuals who previously purchased coverage on a Guarantee Issue basis may apply for additional coverage up to the GI limits established for the case or to the maximum Simplified Issue.

Total amount purchased on a Simplified Issue may not exceed a total of all policies inforce for an amount of $30 a week on an employee, $15 per week on spouse, or $5 per week on dependents, (children and grandchildren).

Individuals who previously met eligibility requirements, but waived coverage on themselves and/or family members at either the original enrollment or at a past re-enrollment, will be eligible for Simplified Issue only.

Only premium paying policies are counted toward the GI/SI amount.

OPEN RE-ENROLLMENTS

Newly eligible employees or employees, who previously waived coverage, may apply for coverage on a Guarantee Issue basis in accordance with the Guarantee Issue limits for the case. This also applies to spouses, children and grandchildren. Individuals who previously purchased coverage on a Guarantee Issue basis may apply for additional coverage up to the GI limits established for the case or to the maximum Simplified Issue.

Total amount purchased on a Simplified Issue may not exceed a total of all policies inforce for an amount of $30 a week on an employee, $15 per week on spouse, or $5 per week on dependents, (children and grandchildren).

Only premium paying policies are counted toward GI/SI plan limits.

Both the re-enrollment guidelines and open enrollment guidelines apply only every 12 month period.

CHILDREN'S INSURANCE

When enrolling Children the employee/spouse chooses between the Children's Term Rider (CTR) or the children's permanent policy. The CTR is GI if this is the employee's/spouse's first opportunity to purchase coverage and there is GI available. If the employee/spouse has a prior policy and failed to purchase the CTR, the rider is simplified issue (SI). If the employee is a late enrollee and the application is SI, the CTR is also SI. If there are newly eligible children and this is the first opportunity to purchase on those children, they will be GI. GI is determined based on date of hire, last enrollment date, coverage in force and child’s date of birth.

When the employee and spouse are employed with the same company they both have the same GI/SI options.

On subsequent re-enrollments the employee/spouse may add either the rider or individual policy.

APPLICATION SUBMISSION

Proper application submission is very important to assure timely policy issue and accurate billing of the client company. All applications must be received **no later than 3 weeks prior to the issue date established.**

Paper Applications should be sent securely via the Boston Mutual Website, www.BostonMutual.com, by selecting Issueapplications@bostonmutual.com, (Only if your agency has the ability to encrypt e-mails to send securely to our website. It is important that we protect the personal and medical information on the applications), or by mailing to the following address along with the required forms:

BOSTON MUTUAL LIFE INSURANCE
COMPANY ATTN: ISSUE DEPARTMENT
120 ROYALL STREET
CANTON, MA 02021

Electronic Enrollment files should be e-mailed to: edi@bostonmutual.com

The following forms are required upon submission with paper applications:

Case Transmittal (Exhibit 7) **–** A completed transmittal must accompany all submitted paper applications. For a new case, it should be filled out completely, including policy issue date, case number *(which is assigned prior to the enrollment by the Home Office)*, employer name, address and phone number, list bill contact and how the list bill is to be set up. When submitting re-enrollment business, the top portion of the report needs to be completed unless changes are required. Also, indicate the annualized premium in the lower right hand corner and any commission information. On a re-enrollment, if the commission splits are to remain the same as the previous enrollment, leave this section blank.

- **Enroller's Report** (Exhibit 8) **– A completed enroller's report m**ust accompany the paper submission of applications. The Enroller's Report is an important tool in the underwriting process and the payment of advances and commissions. It is not necessary to use this form if a computer-generated report is produced by the agency containing the same information.

- **Payroll Authorization/waiver cards –** If required by the employer, a completed payroll authorization should be submitted with the applications.

- **Employer Agreement** (Exhibit 1) **–** This form must be submitted with the case set up documents.

POLICY ISSUE

The Issue Team processes all new business. Our goal is to work closely with the Servicing Agency/Enrollers to process these applications as quickly and accurately as possible.

Case Set Up: Applications are matched to their case file, which includes the approved data report. Each application is set up scanned and assigned a policy number.

Data Entry: List bill numbers are assigned to new cases or existing list bill numbers are verified. All pertinent information from the application is data entered, including information regarding the list bill. For electronic application the data is uploaded into the system.

Underwriting: Guarantee Issue/Simplified Issue limits are confirmed for each application. Applications are underwritten based on information on the application and they are approved, reduced to GI or declined. The Case Coordinator will request any additional information required via a pending report.

Issue of Policies: Policies are issued and a copy of the application is included with each policy. Policies are placed in a window-mailing envelope.

Turnaround time for policy issue is 10 - 20 working days. Turnaround time may differ depending upon case size and the number of pending applications. Any application pending more than 60 days after receipt will be closed. Any premium received will be refunded.

Approved policies will be mailed directly to the insured's home/mailing address. The policy includes two copies of the policy illustration. One copy must be signed by the insured, and returned to the home office in the postage paid envelope, which is included with the policy.

The following information will be e-mailed to the Servicing Agent after the underwriting is completed:

Pending Report: A pending report is sent to the Servicing Agent on pending applications.

Laser Issue Report: This report provides a summary of applications received, policies issued, assigned policy number, withdrawn and declined applications.

Deduction Change Report: Summary of deduction discrepancies and reasons. Agents are responsible for notifying the company of any changes after the initial enrollment. A copy of this report is also shared with our Premium Services Department.

Letters: Copies of all cancellation, reduction, and decline letters.

PREMIUM ACCOUNTING

Establishing Your Account with pre-deductions:

Boston Mutual Life requires 5 weekly deductions, 3 biweekly deductions, 2 semi-monthly deductions or one monthly deduction in advance of the policies' first premium due date. Premiums are deducted in advance of the bill date so when the payment is due, the premiums are on hand to pay the bill. Premium due dates are either the 1st or the 15th of the month. We are able to work with flexible payroll deduction schedules, including 10-month schedules. Premiums can be remitted after each payroll or on a monthly basis.

Establishing Your Account with not pre-deductions:

If you are not pre-deducting, the deductions should start on the first payroll of the month issued. If there are only 4 weeks, or 2 bi-weeklies, in that month, the first month will not move the policies from Issue to in force, and will not generate commissions. Due Dates and deduction schedules remain the same.

Reconciliation

The employer has the option of reconciling payments online using our Web Billing program or by submitting an electronic file of all deductions withheld and we will do the reconciliation for them. Terminations and leave of absence dates should be noted on the electronic file. Files can be directly uploaded to our secure FTP site.

Both methods of reconciliation result in Boston Mutual providing missed deduction letters directly to employees missing deductions.

Payments can be submitted to our lock box or via wire transfer. Premiums can be remitted after each payroll or on a monthly basis within 10 days of the due date.

Instructions are below for sending payment.

Lock Box for Payments: **BOSTON MUTUAL LIFE-W**
PO BOX 55153
BOSTON MA 02205-5153

ACH/Wire Instructions: When wiring funds the following information is required:

BANK NAME AND ADDRESS:

- JP Morgan Chase, One Chase Manhattan Plaza, New York, NY 10005
- ABA NUMBER: 021000021
- ACCOUNT NAME: BOSTON MUTUAL LIFE INSURANCE COMPANY
- ACCOUNT NUMBER: 9102717015
- MESSAGE LINE: ATTN: WORKSITE ADMINISTRATION

For questions regarding Premium Collections and Web Billing, please contact:

Angie Maskell, *Manager*	Ext 512	e-mail Angie_Maskell@bostonmutual.com
Sue Jorge, *Supervisor*	Ext 434	e-mail Sue_Jorge@bostonmutual.com

WEB BILLING

Boston Mutual's list bill is designed to match the frequency of the client company's payroll whether it is weekly, bi-weekly, semi-monthly or monthly. It can be sorted alphabetically or by SSN.

The summary page of the bill indicates the total amount due for the month. The bill lists employee name, insured, policy numbers, coverage type, deduction amount, number of deductions due *(based on an internal calendar calculation)* and total amount due. The employee name will always appear on the bill. To review coverage detail including type of coverage and insured just click on the employee name.

If an employer notices any discrepancies on the bill, they should contact their Boston Mutual Account Representative for immediate correction or it may be noted on the bill.

A remittance sheet and check should be submitted to the address on the bill to insure timely and accurate processing. We also offer ACH in lieu of a manual check. The employer should notify their Account Representative if they would like to utilize this option. The following information should be used when wiring funds to our bank, JP Morgan Chase.*

CONSERVATION PROCESS

The following conservation efforts will be completed for employees who have terminated, have elected to cancel their policy, or are on a leave of absence. These policies will be deleted from the next month's list bill if notification is received 5 days prior to the next billing date.

TERMINATED EMPLOYEE: TERMINATED EMPLOYEE: Within five working days of receiving the final payroll deduction and notification of termination to Boston Mutual, a conservation letter will be sent to the employee**.** An Insured can elect their payment option going forward including Monthly Coupon book, Electronic Fund Transfer (EFT) or Annual, Semi-Annual and Quarterly billing. If there is no response and payment is not received within 30 days, the policy will lapse or the Automatic Premium Loan Provision (APL) will be used. If the Life policy has additional cash value, a monthly coupon book will be generated for payment option.

CANCELLATION OF POLICY: Within five working days of notification to Boston Mutual, the employee will receive the necessary forms for cancellation. The cancellation form must be signed by the owner and returned to the Home Office for the cancellation of the policy. If the form is not received within 30 days a coupon book will be sent. If no payment is received the policy will lapse accordingly or the APL provision will be used. If the Life policy has additional cash value, a monthly coupon book will be generated for payment option.

LEAVE OF ABSENCE (LONGER THAN SIX WEEKS): Within five working days of receiving the final payroll deduction and notification of termination to Boston Mutual, a conservation letter will be sent to the employee**.** An insured can elect their payment option going forward including Monthly Coupon book, Electronic Fund Transfer (EFT) or Annual, Semi-Annual and Quarterly billing. If there is no response and payment is not received within 30 days, the policy will lapse or the Automatic Premium Loan Provision (APL) will be used. If the Life policy has additional cash value, a monthly coupon book will be generated for payment option.

MISSED DEDUCTION: Within five working days, a letter is sent to the employee when missed deductions are $10.00 or more and one month behind the bill, with options of double deduction or direct payment. Nonpayment will result in a non-current paid to date and could cause the policies to lapse.

LIFE INSURANCE REPLACEMENT REGULATIONS

REPLACEMENT GUIDELINES

The Navigator, Boston Mutual's guide for ethical market conduct, is provided to all agents, upon contracting with the Company. They must read it and sign an acknowledgement of compliance. This guide can be found in the Company's website. **The Navigator** defines Replacements as follows:

REPLACEMENTS

Replacement refers to any transaction in which a new life insurance policy is to be purchased or changed *(as described below)* and it is known or should be known to the proposing distributor or the proposed insurer that because of such transaction, an existing life insurance policy has been or is to be

- Lapsed, forfeitured, surrendered, or otherwise terminated;
- Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of non-forfeiture benefits or the policy values;
- Amended to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force for which benefits would be paid;
- Reissued with any reduction in cash value; or
- Pledged as collateral, subjected to borrowing, whether in a single loan, or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding 25% of the loan value set forth in the policy.

When one or more of the listed activities have occurred, the original policy will be considered to be replaced.

If the clients are considering replacing existing policies with new ones, the agent can provide a valuable service by helping them to evaluate whether a replacement is in their best interest. ***Replacements are almost always not in the best interest of an insured.*** The agent needs to fully inform the client on the benefits and disadvantages of such a replacement, as it directly affects him or her.

The agent is required to help the client evaluate the advisability of replacement by reviewing with him or her, the following factors regardless of whether a Boston Mutual policy is the new policy, the policy being replaced or both.

- What is the difference in the premium, projected values, benefits, and the limitations and exclusions between the policies?
- Most replacements result in the incontestability period starting over with a new policy.
- Is the underwriting class under the new policy as favorable as it was under the old policy?
- Would the benefits of the new policy outweigh the new and possibly higher costs?
- What advantages, if any, does the new policy offer?
- Does the existing policy have options that either are not available under the proposed policy or will not become available until later?
- How quickly will any cash values and dividends of the replacement policy grow?
- Is there a surrender charge to get out of the old product?
- Are the annual fees and new surrender charges higher for the new product?
- Will there be a new surrender charge period for the new product?
- Can the client realistically expect to live long enough past the surrender charge period to receive the benefits of a replacement policy?

- Has the client's health history changed since purchasing the existing insurance?
- Are there any possible tax consequences resulting from canceling the old policy and replacing it with the new one? It may be a good idea to recommend that the client check with a tax advisor.
- Is there a significant difference in the comparative financial ratings, *(A.M. Best, Duff & Phelps, Weiss, Moody's etc.)* assigned the new company versus the ratings of the old company?

This is not intended to be an exhaustive list of all possible considerations involving the advisability of any specific replacement. In the end, clients must make their own decisions regarding what they believe to be in their best interests. However, a quick review of these issues and tools will assist clients in making an informed decision concerning the advisability of replacement.

Questions asking about the possible replacement of another policy are included in all Boston Mutual applications. The questions are asked of the prospective policyholder and of the agent. The questions are required by the state that approved the use of the application, and most states also require the completion of a replacement form with the application. If a replacement is involved, in any state, Boston Mutual requires a number of forms to be completed and signed by both the Applicant and the Agent and attached to the application. The forms that need to be completed are: (1) Replacement form applicable to the state *(Boston Mutual requires the standard replacement form #NB47 7/00 if the replacement is involved in a state that does not require a specific form)* and (2) Form NB104 *(Revised 7/07) (Understanding of Policy Change or Replacement)*.

The Navigator also states that Boston Mutual is committed to promoting insurance sales in the best interest of the customer. With that in mind, the company requires that its agents communicate to the customer clearly, accurately and fairly, the information that the customer needs to determine whether replacement of existing policies or contracts may or may not be appropriate. It also warns that replacing an insured's coverage without complying with all applicable laws and regulations, or acting indiscriminately may subject the agent and the company to fines, penalties and other legal consequences.

LICENSING & CONTRACTING

Direct Brokers, General Agents and Agents must be contracted, licensed & appointed by Boston Mutual Life Insurance Company in the states in which they will be soliciting applications for insurance prior to the actual case enrollment. Contracts must be initiated through the Regional Director, completed by the individual and/or corporation and forwarded to the Licensing Department at the home office for processing.

The processing procedure could take up to 10 (ten) business days so please plan accordingly. The process includes: a Vector Balance Inquiry, credit and criminal background checks, appointment to the relevant state(s), and contract processing.

In addition, in order to meet our responsibilities under the USA PATRIOT ACT, we provide an online Anti- Money Laundering training course through QuestCE. Producers are required to complete the training prior to selling or enrolling a case for Boston Mutual.

Enrollers for the respective General Agent or Direct Broker are also required to be licensed and appointed by Boston Mutual. Enrollers are subject to the same appointment procedures as the General Agents & Direct Brokers. All entities and individual producers need to complete the Producer's Application and submit the form along with a current photocopy of the relevant state license to the home office for processing and subsequent appointment.

In states where an Enroller is required to be licensed and appointed, the General Agent or Direct Broker is also required to be licensed and appointed in that state. An Enroller's appointment will not be processed without the General Agent or Direct Broker being appointed in that state.

The above rules must be strictly adhered to.

CUSTOMER CARE INFORMATION

Once a case is written and policies are issued, there is a continuous need to provide service to each insured depending on his/her individual situation.

For items of service, the General Agent should route all requests to Customer Care Services. In addition, we must be notified when an insured wishes to change an address, change a beneficiary, change the ownership of a policy, and/or change of name. A Service Request Card is enclosed with each policy which can be used to initiate these or other service requests.

All policy service forms can be accessed from our website at www.bostonmutual.com or requested from our Customer Care Team, at our toll free number 1-877-624-2249.

How to Request a Not Taken under the 30 Day Free Look Provision

Description: A Not Taken occurs when a policy owner decides, within the free look period, or within 30 days from the date the policy owner received the policy to cancel the policy. To do so, the owner must return the policy to Boston Mutual along with a written authorization to cancel.

All premiums received on a not taken policy will be refunded to the Policy owner within 5-10 working days after receipt of the request.

If an insured wants to cancel his/her policy prior to receipt, a written request must be signed by the owner and sent to the Home Office.

How to Request a Cancellation

Description: If an employee requests to cancel his/her policy after the free look period, written notification should be given to the employer listing the policy numbers to be cancelled. This will alert the employer to stop deductions and notify Boston Mutual on the next monthly list bill. Cancellation can also be requested by the insured directly to the Home Office.

Upon notification from the employer, a cancellation form will be sent to the employee's home address. The request for cancellation must be signed by the policy owner and returned along with the specification page of the policy. If the policy cannot be located, refer to the section on Statement of Policy Loss.

Boston Mutual will do one of the following in the event of a cancellation:

No cash accumulation: The policy will lapse as of the paid to date of the policy and a notice will be for- warded directly to the employee/owners home address.

Cash accumulation: Cancellation will be processed, upon receipt of the cancellation form, and a check for the cash value amount, less any amount the policyholder owes us, will be sent to the employee/owner's home address.

How to Request a Cancellation of Smoker's Surcharge

GENERAL INSTRUCTIONS

Requirement: An application change form, (#144-WM-C), application questions form, (#145) and tobacco questionnaire must be completed to consider a Smoker Surcharge removal.

The Smoker Surcharge removal may be requested if the insured has not used tobacco or nicotine products, *(this includes the e-cigarette)* within 12 months and the policy has been **in force for at least 2 years.** Indicate the date the insured last used tobacco or nicotine products and complete all sections including medical section. If the applicant has experienced a change in insurability that is related to tobacco use, the request may be denied.

Employee must complete all sections, date and sign the authorization and agreement section.

How to Request a Beneficiary Change

Description: The owner can download a beneficiary change form from the Boston Mutual Website or by requesting the information by mail, telephone or fax. The owner must complete a Change of Beneficiary form. This form should include the relationship to the beneficiary, date of birth, and if possible, the beneficiary's address. Please complete a separate form for each policy number.

The form must be properly dated, signed and witnessed.

The total percentages for Primary and Contingent Beneficiary must total 100%.

Once the beneficiary change has been recorded, a Customer Care Service representative will send a confirmation of the change to be placed in the policy contract.

How to Request a Name Change

Description: The request must be in writing with the owner's signature.

- Complete a Request for Service Form; or
- Utilize the Customer Care Service Card contained in the policy; or
- Submitted in writing by the owner

How to Request an Address Change

Requirements: No formal documentation required, however, please remember to list all policy numbers.

- Request can be made on the Request for Service Form or by telephone; or
- By employer or agent/enroller; or
- On a Customer Care Service Card enclosed with the policy.

A letter of confirmation is sent to the owner when the change requires legal proof.

How to Request a Policy Loan

Requirements: If eligible, request can be made after the first policy anniversary date. The owner can borrow up to the policy's loan value. The loan value is equal to: the policy's cash value less interest to the end of the policy year on the cash value: less any amount the owner already owes with interest accrued to the end of the policy year; less any premium due and unpaid. The loan interest rate is 8%. **Requests for loans can be completed over the phone for amounts under $5,000. The owner may call our toll free number at 1-877-624-2249.**

- The policy must be the only security for the loan.
- The loan plus any existing debt must not exceed the maximum loan value.
- The policy must be premium paying and paid within 60 days of the current month.
- In order to obtain a loan over $5,000, the owner must complete a Loan Request Form.

Interest on a loan is calculated at the end of each policy year (Anniversary Date) and on the date the loan is repaid. Interest that remains unpaid after the policy anniversary date will be added to the loan balance and becomes part of the principal of the loan. The loan can be repaid in full or in part, at any time before the policy terminates. Loan payments will be applied to the cash reserve that is securing the loan. **Any checks sent should clearly indicate the policy number and that it is a loan payment.** In the event of the death of the insured, the face amount less the current loan balance will be paid to the beneficiary.

How to Initiate a Reinstatement

Requirement: A policy may be reinstated within five years after it has lapsed due to nonpayment of premiums. An Application for Reinstatement must be sent to Boston Mutual. Evidence of insurability must be provided for all family members covered under the policy, along with the remittance of all back premiums necessary to reinstate the policy.

- Complete a Reinstatement Application Form.
- Complete all sections, date and sign the authorization and agreement section.
- Return the properly completed signed form to Boston Mutual along with a check in the amount needed as indicated above.

If the reinstatement is approved by the Underwriting Department, the policy is active and the owner is notified.

If the reinstatement is not approved, the Underwriting Department will notify the applicant with a letter of explanation, and all premium submitted with the reinstatement application will be refunded to the insured.

The Incontestability and Suicide Exclusion Provisions of this policy apply from the effective date of reinstatement.

How to Request a Duplicate Policy

An owner may use Section III of the Request for Service form, date and sign the bottom and return this form along with a check for $10.00 to Boston Mutual Life Insurance Company.

If the $10.00 payment is not received, a Certificate of Insurance will be sent to the owner.

How to Request a Certificate of Insurance

Requirement: A Certificate of Insurance is a brief outline of an owner's contract. If a policy has been lost, Boston Mutual will issue a Certificate of Insurance to an owner free of charge. Complete Request for Service Form, date and sign the bottom or by contacting our Customer Care Team at (877) 624-2249.

How to Request Ownership Change

Requirement: Ownership of a life insurance policy is extremely important. Ownership may be transferred to another, who will have all rights as owner on the effective date of the transfer.

A Change of Ownership Form must be completed, dated and signed at the bottom *(reverse side of this form gives detailed instructions)*.

If the ownership is being changed, the original owner can still pay via payroll deductions. If payroll deductions should continue please indicate. Once ownership is changed, the original owner cannot request any information or changes on the policy.

When the owner of an insurance contract dies after the policy has been issued, the policy application contract will state to whom the policy should go to, (beneficiary or insured).

The executor or in some cases the administrator of the estate will need to provide Boston Mutual with information as to who is the correct party to be named as policy owner. In some cases we may need a hold harmless agreement.

Policy Corrections and Changes

Corrections or Changes in Policy Contract

Policy Correction: A Correction in a contract occurs when Boston Mutual issues the policy contract with incorrect information in relation to the application on items such as age, amount, death benefit option, and riders. If this occurs, notify the Home Office by telephone or letter. Boston Mutual will make the necessary adjustments and forward a corrected policy to the owner of the policy.

Changes in Policy Contract

Addition of Riders:

Requirements: The owner of a policy may add a rider during the re-enrollment period, provided that the policy is paid to a current date. Availability of riders depends on the plan, face amount, and the issue age. Evidence of Insurability must be provided unless the case is approved for an open enrollment.

The Owner must complete an Application for Contractual Change and Form #145. For the Children's Term Benefit Rider if medical questions are required the medical questions relate to the children and insured. If approved, the riders are added as of attained age. Boston Mutual will send an Amended Policy Specification Page and the Rider Page directly to the owner of the policy.

Conversion of Children's Term Rider

Requirement: The owner must complete an Application Change form and an application. The child must be between the ages of 21 and 26. The amount of conversion is up to 5 times the amount of the rider not to exceed $25,000. Evidence of Insurability is required for the addition of any riders to the converted policy. The Proposed Insured's signature is required as well as the first month premium.

NOTE: The Children's Insurance Benefit Rider will not be removed from the existing policy unless requested by the owner.

Deletion of Riders and Benefits

Requirements: The owner of a policy may delete a rider any time the policy is in effect.

The owner must complete an Application for Contractual Change. Upon receipt of the properly completed form, the change will be effective the following month. **In order to process all changes, policies must be paid to current date.** An Amended Policy Specification Page is mailed directly to the owner of the policy.

CLAIM FILING INFORMATION

When a claim is incurred, notify Boston Mutual as soon as possible by calling 1-877-212-2950. Claim forms, Exhibit 9, can also be down loaded from our website at www.bostonmutual.com.

Instructions for filing specific types of claims are as follows:

LIFE INSURANCE

Death: In order to process a death claim quickly we require a claim form completed by the Beneficiary, a clear copy of the insured's death certificate and the policy if available.

RIDERS/BENEFITS

Accidental Death: If death is caused by accident the procedure is the same as above. It would also be helpful to provide a newspaper article or police report.

NOTE: Death claims are not always easily processed. There are times when certain causes of death are not covered under a policy *(for example suicide, death while committing a felony etc. under the Accidental Death Benefit rider; or suicide within the first two years of coverage under the basic benefit).* Unless fraud exists on the application most Guaranteed Issue benefits will be paid without question, but there are times when the amounts over the Guaranteed Issue portion of the policy must be investigated. This could also be true of any suspicious or accidental death claim. The uncontested portion of any death claim will be released as soon as possible even if further investigation is needed on the rest of the claim.

CHILDREN'S INSURANCE RIDER

When a death occurs on a child either through a separate policy or through a rider of a parent's policy, this is handled as outlined above under normal death. Please be aware, that under some circumstances the children's rider is written on a simplified issue basis. In these instances, the two year period of contestability applies and as such the payment of claims may be delayed.

WAIVER OF PREMIUM

This rider is intended to provide continued premium payments for the policy and riders, if an insured becomes totally disabled prior to his/her sixtieth birthday. **NOTE: This rider may be subject to certain exclusions. Please refer to the rider page in the policy itself for contractual exclusions.**

FILING A CLAIM

If an insured's disability is expected to last six or more months, after four months the insured should complete a Waiver of Premium Claim Kit. If the claim is approved, Boston Mutual will reimburse the insured for the premium paid for the first six months of the disability.

COMPENSATION

COMMISSIONS

Commissions are processed every other Tuesday. If all deductions are received to pay one full monthly premium, (4.333 weeks), commissions will be automatically generated and are paid as earned.

Commissions are paid on a case level and can be split can be split between three entities, General Agents, Direct Brokers or Agents and all must be licensed in the enrollment state and appointed with Boston Mutual in those states.

Commission statements can be accessed on the Boston Mutual web site – www.bostonmutual.com.

Commission spits are determined during the case set up. As part of the implementation process, the agent of record will be sent a Commission Distribution Form, (Exhibit 10), to be completed and sign off on the splits. If in later enrollments the splits change, a new Commission Distribution Form will be requested.

COMMISSION RATES

ELOP Commissions:
90% First Year
6.5 % Years 2 thru 10
3% Service Fee - 11+

Commission checks are mailed or direct deposited on Thursday, (depending on the payee's bank), of the commission run week.

COMMISSION STATEMENTS

Commission information is available on the Boston Mutual Web page on Wednesdays of a commission week. Commission information is broken down by case and then policies within the case.

The amounts are totaled at the end of each case and broken down by first year and renewal commissions.

The Agent Total Page shows the total of all first year and renewal commissions paid to the controlling GA. The Agency Total Page summarizes the total commissions paid to your agency *(including any agents/brokers)*.

The Agency Synopsis Page breaks down current and year to date totals by case, listing them by first year and renewal.

ADVANCES

Advances can be paid to General Agent and Direct Brokers upon request. This is typically established during the first came implementation. The entity will need to sign an Advance Agreement.

Upon submission of $5,000 or more of annualized premium in new business, Boston Mutual will advance a maximum of 25% of the annualized premium for Life business.

The advance would be prorated based on the percent of commission split. Advance checks are mailed or direct deposited on Thursday, (depending on the payee's bank), of each week.

The advance will be recovered from your total earned commissions and not on a case by case basis. The recovery amount will be 10% per month of the original advance over a ten month period beginning with the issue date of the case.

Accounts are reviewed monthly for any advance debt. Any debt will be assessed and potentially collected outside commissions. Any accounts with outstanding debt may result in a hold on any future advances until the debt is cleared.

STATUS OF AGENCY

If you have received advances, you will see the Status of Agency Account page at the end of your commission statement. This page will show you:

Case number - 5 digit number assigned by Field Services.

Start Date - Month in which recovery will commence.

Original Advance - Amount of original advance or sum of advances on the same case number and start date.

Current Payment - 10% of original advance due. This amount will be recovered in the first pay period of the month.

Past Due - Monies due if Boston Mutual was unable to recover payment due in the previous month.
Current Balance - Amount of advance balance.

MONTHLY REPORTS

ORDINARY LIFE REGISTER

This report details any and all activity within a case for each reporting month. Each policyholder is listed with information including original issue date, premium, amount of insurance and the transaction type. It also gives a breakdown of the number of policies in force, total annualized premium and insurance in force which is listed as "Current" for the current month and "Contract" from the inception of your contract.

MONTHLY PRODUCTION SUMMARY

This report summarizes the Ordinary Life Register by listing the annualized totals by case:

- Lists Paid & Issued, 1st year Lapses, Not Taken, and Bonus. Indicates Controlling or Writing Agent/GA.
- Summarizes the Total Production for the month by Bonus & Convention. Submitted & Not Taken numbers apply to Controlling General Agency.

PERSISTENCY REPORT

Directly addresses the long-term Persistency performance on a case and producer level basis. It includes all enrollment dates, number of issued policies, not taken, lapses and in force policies. It also breaks down Persistency by 13th month & 25th month percentages. This report is run quarterly and is monitored by the Home Office.

AGENT WEB ACCESS INSTRUCTIONS

For activation and/or questions please contact:

Kimberly Olson (Kimberly_Olson@bostonmutual.com), 1-800-669-2668 x250,

Boston Mutual Agent Web Features:

- Information Board
- Sales Support/Services
- Commissions
- Reports (Monitor your block of business)
- Compliance – Practices, Bulletins & Articles
- Email Us – For your Security: This system utilizes Internet encryption technology (SSL) to help ensure safe and secure transmission of your information.

To gain access to the agent web please see below:

1. Log on to www.bostonmutual.com
2. Click on "Agent & Brokers" – agent login.
3. You will enter your 5 digit payroll number as the username and then enter your payroll number again as your password.
4. If you are not sure of your payroll number, please check your commission statement or the top of your check stub where it reads "file no." (only use the last 5 numbers, dropping the zero at the beginning).
5. You will be prompted to change your password. Simply pick a unique 6 to 10 character password that will be easy to remember and you're ready to access your information. You will not be allowed to keep your payroll number for your password.
6. When you are finished, be sure to log out of the Agent Web.

PROPER HANDLING OF CORPORATE COMPLAINTS

Each of us plays an important part in the life cycle of an insurance policy including the treatment of our consumers. We all strive to be honest and fair in our dealings with our customers. However, situations occur where information is miscommunicated or policyholders feel their wishes have not been carried out. Oftentimes, this leads to a complaint against the agent or the Company.

There are several ways that we learn about how we are doing from our policyholders. We formally solicit our new policyholders' opinions through Customer Satisfaction Surveys. In addition, we send out Customer Service Surveys to our customers who call the Home Office or send written correspondence for service. Corporate Complaints are an unsolicited but a valuable form of policyholder feedback.

A complaint is defined as any written or documented verbal communication received by the Company or its distributors which primarily expresses a grievance. If you receive a complaint, you should forward to the Chief Compliance Officer where handling procedures will be followed. We are extremely sensitive to complaints and have a comprehensive system to handle them quickly and equitably. Complaints are a regulated component of our business; therefore it is important that Compliance is notified immediately. If there is any question as to whether a communication is a complaint, it should be referred to the Chief Compliance Officer for review.

Boston Mutual is required by law to maintain a corporate complaint register. During a market conduct exam, a state insurance examiner will ask to review our Complaint Register. Therefore, it is very important to record all complaints, resolve them promptly and satisfactorily, respond within the time frames mandated by the various state insurance departments, and to take appropriate action to prevent future occurrences.

BOSTON MUTUAL FAIR COMPETITION POLICY

The Company is committed to competition as the most effective and efficient means of providing our customers with the widest array of meaningful products and services. Competition is also the most efficient regulator of activities within the marketplace. In order to foster fair competition, the following guidelines should be adhered to by all distributors.

1. Representations regarding the benefits or terms of our policies must be accurate, true, and not deceptive or misleading. Representations regarding the financial condition of the Company must be accurate and complete.

2. In most states, inducing a client to purchase insurance through returning a portion of your commission or providing any item of value is an illegal practice. This means that in any sale of insurance, you must not offer any gift, which is contingent upon the purchase of insurance.

3. It is unlawful for any person to maliciously criticize or disparage another insurer or its representative. An agent should seek to promote the good name and reputation of Boston Mutual Life Insurance Company and avoid incomplete, unfair or inaccurate comparisons to other companies. Questions about the reputation of other insurers raised by your clients should be referred to the appropriate state insurance department.

4. Discrimination based upon race, religion, nationality, ethnic group, age, sex, or marital status is prohibited; as is coercing, boycotting, limiting or restraining trade through intimidation or other means.

5. Instead of negatively focusing on competitors or back-door methods of selling life insurance, focus on the positive side of selling our Company and its products. A good attitude about the right product will help develop potential clients into satisfied policyholders.

6. Should a market conduct or ethical situation arise which cannot be handled through your normal chain of command, please call Christine S Williams, 2nd Vice President, Chief Compliance, Privacy, and Anti-Money Laundering Officer Compliance, (800) 669-2668 x422.

AUTHORITY OF AGENTS

The authority of an agent is set out in his/her contract, which can only be modified by the Home Office in writing.

Authority is limited to: securing applications on plans offered by the Company, collecting initial premium, delivering policies, and performing such other duties as may be specifically authorized by the Company.

The agent is a representative of the Company, but does not have the authority to:

- Approve applications for new insurance or for reinstatement
- Alter or modify applications or policies
- Extend the time for payment of any premium Incur any indebtedness in behalf of the Company
- Employ legal counsel to represent the Company
- Write checks on behalf of the Company, pay claims on policies or cash values under surrendered policies, or waive forfeitures
- To operate a call center without entering into a separate agreement with the company
- Collect additional premium on behalf of Boston Mutual without proper agreements/ authorization

FRAUD WARNING

Fraud is defined as:

An intentional act of deception, misrepresentation or concealment done in order to gain something of value or an intentional deception deliberately practiced in order to secure unfair or illegal gain.

As an insurance producer, your skills and services help your clients achieve financial security. Because you are on the front lines of a multi-billion dollar industry, you are in a unique position not only to serve your clients, but also to serve the rest of society by helping to prevent fraud.

To comply with the various state laws concerning fraud, Boston Mutual Life Insurance Company has adopted certain procedures for detecting and reporting fraud. You have an important role to play in that program. As a person who is in direct contact with customers, you will often be in a critical position to obtain information regarding the customer, the customer's source of funds for the products you sell, the customer's reasons for purchasing an insurance product and whether there is any suspicion that your customer may be trying to commit a fraud.

Boston Mutual and its producers share an important responsibility to comply with the various fraud laws. A failure to do so may expose those responsible to substantial penalties under state and federal laws. Any suspected fraud should immediately be reported to Boston Mutual's Chief Compliance Officer for review and referral to the outsource Special Investigative Unit (SIU) as appropriate.

CHRISTINE WILLIAMS
2nd Vice President, Chief Compliance,
Privacy and Anti-Money Laundering Officer
Compliance Department
120 Royall St, Canton, Mass 02021
christine_williams@bostonmutual.com
1-800-669-2668 x350

EXHIBITS

Exhibit 1: Employers Agreement

Exhibit 2: State Approvals for Product and Riders

Exhibit 3: ELOP Brochure for Employees

Exhibit 4: Standard Application

Exhibit 5: Spouse/Dependent Signature Card

Exhibit 6: Notice of Information Privacy Practices

Exhibit 7: Case Transmittal

Exhibit 8: Enroller's Report

Exhibit 9: Claim Form

Exhibit 10: Commission Distribution Form

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 Royall Street • Canton, MA 02021 • T: 800.669.2668 • F: 781.770.0575 • www.bostonmutual.com

FAMILY MATTERS. NO MATTER WHAT.

EMPLOYER'S AGREEMENT

To: Workplace Solutions Sales and Service

Company Name:

Will withhold premiums for Boston Mutual voluntary insurance product(s) sold to its employees. We agree that each employee will be allowed to attend a scheduled group meeting and/or meet individually with an insurance sales representative on company time and premises.

We agree until further notice to honor payroll deduction requests made by the employees for coverage they may apply for. Deductions will be made systematically and prior to the date due. We agree to promptly forward, within 10 days, the amount deducted upon receipt of your monthly statement. Payment will include accurate reporting of deductions taken for each employee and will enable Boston Mutual to apply policy payments accurately.

We understand and agree that we are acting on behalf of our employees and that if such payments are not received by you, within the grace period allowed by the insurance policy coverage will terminate.

We assume no responsibility for payment except for payroll deductions previously made and we have the right to discontinue this agreement at any time after 90 days written notice to Boston Mutual. We will promptly notify you upon termination of any participant. It is our understanding that any employee may elect to withdraw from the program and discontinue payroll deductions.

Employees/members eligible to enroll for this coverage:

- **Number of regular full-time employees/members: _____ Other:_____**

A Full-time employee/member is defined as one who works _____ hours or more per week. An employee/member must be Actively at Work on the date he/she applies for insurance, and on the date his/her Insurance is to become effective. An employee/member must have completed _____ months of continuous service before being eligible.

Date: _____

Name: _____
Title: _____
Authorized Signature: _____

Whole Life (ELOP) Benefit Approval by State								
State	Approved	Catastrophic Loss Rider	Accidental Death Benefit (ADB)	Children's Term Rider	Payor Waiver of Premium	Payor Waiver of Premium For Strike	Level Term Rider	Accelerated Death Benefit (ABOR)*
Alabama	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Alaska	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Arizona	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Arkansas	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
California	Yes	No	Yes	Yes	Yes	Yes	Yes	No
Colorado	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Connecticut	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Delaware	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
District of Columbia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Florida	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Georgia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hawaii	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Idaho	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Illinois	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Indiana	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Iowa	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kansas	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Kentucky	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Louisiana	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Maine	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Maryland	Yes	No	Yes	Yes	Yes	No	Yes	Yes
Massachusetts	Yes	*Chronic Illness Rider*	Yes	Yes	Yes	Yes	Yes	Yes
Michigan	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Minnesota	Yes	No	Yes	Yes	Yes	No	Yes	Yes
Mississippi	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Missouri	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Montana	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Nebraska	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nevada	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
New Hampshire	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
New Jersey	Yes	No	Yes	Yes	Yes	Yes**	Yes	No
New Mexico	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
North Carolina	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
North Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ohio	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oklahoma	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oregon	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Pennsylvania	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
South Carolina	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Revised 04/02/24

Whole Life (ELOP) Benefit Approval by State								
State	Approved	Catastrophic Loss Rider	Accidental Death Benefit (ADB)	Children's Term Rider	Payor Waiver of Premium	Payor Waiver of Premium For Strike	Level Term Rider	Accelerated Death Benefit (ABOR)*
South Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Tennessee	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Texas	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Utah	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Vermont	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Virginia	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Washington	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
West Virginia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wisconsin	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wyoming	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

**Accelerated Benefit is available at claim time. The wording is only included in the proposal for New York.*
***Strike is approved in NJ but not programmed.*
****Not currently doing business in Puerto Rico.*

Whole Life Insurance

What is whole life insurance?

Whole life insurance is more than just life insurance at an affordable price. It combines the guaranteed premiums, coverage, and values that have always been so attractive in whole life insurance with the advantages of cash accumulation at current interest rates.

With whole life coverage you choose the amount of insurance or the amount of premium that best suits your needs and budget.

Our Whole Life workplace insurance is an endowment at age 95 life insurance policy, which means the face value would be paid to the insured, if living, at age 95.

Providing peace of mind for *you* and *your family*

With Boston Mutual's Whole Life coverage…

Just 54% of Americans have any life insurance coverage, a notable decline from 63% just a decade ago.

– 2020 Insurance Barometer Study, LIMRA and Life Happens

- ✔ **Family coverage available.** You don't have to apply in order to cover your spouse, children, and grandchildren.
- ✔ **Guaranteed premium.** As long as you pay your premiums, the cost of your life insurance policy can never go up.
- ✔ **Guaranteed cash value.** The cash value illustrated at the time of purchase, when you reach age 65, is guaranteed as long as your coverage stays in force.*
- ✔ **Guaranteed portability.** Even if your employment changes, you can keep this coverage and pay us directly for the premiums.
- ✔ **Guaranteed additional purchase.** If you buy a minimum amount of coverage, you guarantee yourself the right to purchase any remaining portion of the guarantee issue limit at future approved enrollments *(subject to product and payroll deduction availability).*
- ✔ **Payor Waiver.** Payor Waiver of Premium pays all the premiums on your policy, your spouses or dependent's policy or policies in the event the payor *(employee)* becomes totally disabled before age 60. Automatically included on all policies owned by employees up to and including issue age 55.

* *The actual cash value may be decreased by loans or withdrawals.*

Did you know?

- ✔ **If you have a family,** whole life insurance enables you to build a cash reserve for yourself, your spouse, your children, and grandchildren for less than 1 hour's pay per week. It's a sound way to protect your family without exceeding your present budget.
- ✔ **If you're single with no dependents,** the flexibility of the whole life plan allows you to expand your coverage to meet future responsibilities.
- ✔ **If you are nearing retirement,** obligations and responsibilities have probably come and gone in the past few years. Now you can think about your future. Your whole life plan can be continued after retirement at the same premium.

44% of families say they would face financial hardship if the primary wage earner died within 6 months. For 28%, it would be within just one month.[1]

69% of consumers with life insurance say they are less stressed knowing their loved ones are financially protected with life insurance.[2]

[1] *2020 Insurance Barometer Study, LIMRA and Life Happens*
[2] *2019 Insure Your Love Consumer Survey, Life Happens*

What's the right coverage for you?

We know it's not easy to figure out which insurance fits your needs. Whole life insurance provides protection and financial security that can ensure your family is taken care of when the unexpected happens.

Speak with a representative to talk about what might work for you and your family.

SAMPLE DEFINED BENEFIT PREMIUM RATES & VALUES

The following are illustrations of applicable coverage and cash value accumulation at various ages and contribution levels for the whole life insurance coverage.

Non Tobacco	Issue Age*	Weekly Premium*	Monthly Premium*	Guaranteed Cash Value at Duration 5	Guaranteed Cash Value at Duration 10	Guaranteed Cash Value at Duration 20	Guaranteed Cash Value at 65	Guaranteed Paid Up at 65
$25,000	25	$4.76	$20.65	$286	$1,127	$3,203	$9,790	$20,398
	35	$6.96	$30.18	$518	$1,713	$4,766	$8,751	$18,232
	45	$10.83	$46.95	$922	$2,725	$7,112	$7,112	$14,817
	55	$17.78	$77.05	$1,525	$4,229	$10,426	$4,229	$8,811
$50,000	25	$8.99	$38.99	$572	$2,255	$6,405	$19,580	$40,796
	35	$13.39	$58.04	$1,036	$3,426	$9,532	$17,501	$36,464
	45	$21.13	$91.59	$1,844	$5,450	$14,223	$14,223	$29,634
	55	$35.03	$151.79	$3,069	$8,458	$20,852	$8,458	$17,623
$75,000	25	$13.22	$57.32	$857	$3,382	$9,608	$29,370	$61,193
	35	$19.82	$85.91	$1,553	$5,138	$14,297	$26,252	$54,695
	45	$31.43	$136.22	$2,765	$8,174	$21,335	$21,335	$44,451
	55	$52.28	$226.53	$4,742	$12,698	$31,277	$12,698	$26,456
$100,000	25	$17.46	$75.66	$1,143	$4,509	$12,810	$39,160	$81,591
	35	$26.25	$113.77	$2,071	$6,851	$19,063	$35,002	$72,927
	45	$41.74	$180.86	$3,687	$10,899	$28,446	$28,446	$59,268
	55	$69.52	$301.27	$6,415	$17,131	$41,703	$17,131	$35,693

Tobacco	Issue Age	Weekly Premium*	Monthly Premium*	Guaranteed Cash Value at Duration 5	Guaranteed Cash Value at Duration 10	Guaranteed Cash Value at Duration 20	Guaranteed Cash Value at 65	Guaranteed Paid Up at 65
$25,000	25	$6.40	$27.75	$459	$1,566	$4,250	$11,712	$20,715
	35	$9.98	$43.25	$783	$2,337	$6,102	$10,488	$18,549
	45	$16.49	$71.47	$1,237	$3,499	$8,488	$8,488	$15,013
	55	$26.73	$115.82	$1,864	$4,944	$10,976	$4,944	$8,744
$50,000	25	$12.27	$53.18	$918	$3,132	$8,500	$23,424	$41,430
	35	$19.42	$84.18	$1,566	$4,675	$12,205	$20,975	$37,098
	45	$32.45	$140.63	$2,475	$6,998	$16,977	$16,977	$30,026
	55	$52.92	$229.32	$3,728	$9,888	$21,952	$9,888	$17,489
$75,000	25	$18.14	$78.62	$1,376	$4,697	$12,749	$35,136	$62,144
	35	$28.87	$125.11	$2,348	$7,012	$18,307	$31,463	$55,647
	45	$48.41	$209.78	$3,712	$10,497	$25,465	$25,465	$45,039
	55	$79.11	$342.82	$5,592	$14,832	$32,927	$14,832	$26,233
$100,000	25	$24.01	$104.05	$1,835	$6,263	$16,999	$46,848	$82,859
	35	$38.32	$166.04	$3,131	$9,349	$24,409	$41,950	$74,196
	45	$64.37	$278.94	$4,949	$13,996	$33,953	$33,953	$60,052
	55	$105.31	$456.33	$7,456	$19,776	$43,903	$19,776	$34,977

* Premiums shown include Payor Waiver of Premium. Payor Waiver of Premium pays all the premiums on your policy, your spouse's or dependent's policy or policies in the event the payor *(employee)* becomes totally disabled before age 60. The disability must last at least six consecutive months and meet the definitions set forth in your policy.

This benefit is available for issue on policies owned by employees up to and including issue age 55. This benefit terminates on the policy anniversary on or following the Payor's 60th birthday, as long as the Payor is not disabled at that time.

FAMILY MATTERS. NO MATTER WHAT.®

ABOUT BOSTON MUTUAL LIFE INSURANCE COMPANY

Founded as a progressive life insurance company in 1891, Boston Mutual Life Insurance Company is a national carrier that provides insurance solutions designed for working Americans and their families, as well as enrollment and billing options at the workplace. With its home office based in Canton, Massachusetts, as a mutual company, Boston Mutual Life is dedicated to acting in the best interests of its policyholders, producers, employees, and its communities. For more information, please visit www.bostonmutual.com or contact your Boston Mutual Life representative.

/bostonmutuallifeins

/company/boston-mutual-life-insurance

120 Royall Street, Canton, MA 02021 | 800.669.2668 | www.bostonmutual.com

Application To: **BOSTON MUTUAL LIFE INSURANCE COMPANY**

Individual Life Insurance *(Endowment at age 95)*

120 Royall Street
Canton, MA 02021

PART A

Schedule of Proposed Benefits *(Employee/Owner)*

1. Proposed Insured *(Employee/Owner)* | 2. Gender ❑M ❑F

3. Date of Birth | 4. Age at Issue Date | 5. Social Security # / ITIN# | 6. Telephone #

7. Present Residence *(Required) - include apt. #, Street #, City, State, Zip*

PO Box/Communication Address *(Optional)*

8. Occupation *(Optional)* | 9. Are you actively at work? ❑Yes ❑No

10. Employer | 11. Date of Employment

12. Amount of Insurance $ | 13. ❑Weekly, ❑Bi-Weekly, ❑Monthly or ❑Semi-Monthly Premium $_____

14. Automatic Premium Loan on all Policies? ❑Yes ❑No

15. Additional Benefits:	Amount	Premium
❑ Waiver of Premium	$	$
❑ Accidental Death Benefit	$	$
❑ Children's Insurance Benefit	$	$
❑ Level Term to age 65	$	$
❑ Other _____	$	$

16. Beneficiary for Primary & Contingent - ***Name, Relationship,*** *Address, Telephone #, SS #, D.O.B. (Beneficiary will be employee's estate if left blank)*

Primary:

Contingent:

Schedule of Proposed Benefits *(Spouse)*

17. Proposed Insured *(Spouse)* | 18. Gender ❑M ❑F

19. Date of Birth | 20. Age at Issue Date | 21. Telephone #

22. Present Residence *(St. address)* Same address as employee? ❑Yes ❑No
If NO, provide reason/details in Remarks #30

23. Are you actively at work? ❑Yes ❑No
If NO, provide reason/details in Remarks #30

24. Amount of Insurance $ | 25. ❑Weekly, ❑Bi-Weekly, ❑Monthly or ❑Semi-Monthly Premium $_____

26. Additional Benefits:	Amount	Premium
❑ Payor Waiver of Premium	$	$
❑ Accidental Death Benefit	$	$
❑ Children's Insurance Benefit	$	$
❑ Level Term to age 65	$	$
❑ Other _____	$	$

27. Total Employee Premium $ _____

Total Spouse Premium $ _____

Total Children Premium $ _____

Total Premium $ _____

28. Beneficiary for Primary & Contingent - ***Name, Relationship,*** *Address, Telephone #, SS #, D.O.B. (Beneficiary will be employee's estate if left blank)*

Primary:

Contingent:

29. Have any of the proposed insureds used any tobacco or nicotine products in the past twelve months? *(only complete for smoker/non-smoker policy)* Employee ❑Yes ❑No Spouse ❑Yes ❑No

30. Remarks:

31. Children's Benefits: Employee is Beneficiary, if living, otherwise the employee's estate.

32. Proposed Additional Insured(s) *(children and/or grandchildren)* Name *(first & last)*	Date of Birth Mo Day Yr	Age	Gender M or F	Relationship to Applicant	For Permanent Insurance Only: Premium	Amt. of Ins	ADB Prem	PW Prem	Smoker 18+
									❑Yes ❑No
									❑Yes ❑No
									❑Yes ❑No
									❑Yes ❑No

33. Has the applicant any existing life insurance policies in force? ❑Yes ❑No *If Yes, please complete the Notice of Replacement.*

34. Will the policy applied for replace or change any life insurance or annuities in force on the life of any proposed covered person? If Yes, give the name of the company and policy # being replaced, and enclose any required state replacement forms. ❑Yes ❑No

Company Name _____ Policy # _____

PART B To be completed for any proposed insured *(employee, spouse, children and/or grandchildren)* who is applying for more than the Guaranteed Issue limit. An additional sheet of paper may be attached if needed.

35. Name of Proposed Insured	Relationship to Employee	Height	Weight
		ft. in.	lbs.
		ft. in.	lbs.
		ft. in.	lbs.

36. In the past 5 years have any of the proposed insureds been diagnosed by a member of the medical profession with:

A. (1) asthma, emphysema or COPD *(chronic obstructive pulmonary disease or disorder)*; (2) high blood pressure, stroke, heart or circulatory disease or disorder; (3) intestinal disease or disorder or ulcer; (4) leukemia, cancer, tumor or malignancy; (5) epilepsy, mental or nervous disease or disorder; (6) kidney or genito-urinary disease or disorder; (7) liver disease; (8) pancreatitis *(new or acute)*; (9) thyroid disorder; (10) transient ischemic attack *(TIA)* or (11) disorder of the back, muscles, bones or joints? ❑ Yes ❑ No

B. (1) diabetes requiring insulin, been prescribed or used insulin for the treatment of diabetes, or been diagnosed with or treated for complications of diabetes, including Insulin Shock, Diabetic Coma, Retinopathy, Neuropathy, Amputation, Nephropathy, Kidney disorder or End stage renal disease? ❑ Yes ❑ No

C. (1) having Amyotrophic Lateral Sclerosis (ALS)? ❑ Yes ❑ No

D. (1) having Huntington's chorea? ❑ Yes ❑ No

E. (1) having Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome *(AIDS)*? ❑ Yes ❑ No

37. 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? ❑ Yes ❑ No

38. In the past 5 years have any of the proposed insureds used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, opioids or other habit forming drugs, except as prescribed by a member of the medical profession? ❑ Yes ❑ No

39. In the past 5 years have any of the proposed insureds received medical treatment or counseling for, or been advised by a member of the medical profession to discontinue, the use of alcohol or prescribed or non-prescribed drugs? ❑ Yes ❑ No

40. Do any of the proposed insureds: (1) fly, or intend to fly, within the next 2 years, as a pilot or crew member; (2) race or test any form of vehicle; (3) skin or scuba dive; (4) hang glide or sky dive? ❑ Yes ❑ No

41. Details for questions 36 through 40 answered "YES". Include question number. An additional sheet of paper may be attached if needed.

Name	Disease or Injury	Date Diagnosed	Details - *include treatment & medications*

AGREEMENT AND DECLARATION - Read Carefully Before Signing

I/WE represent that the statements and answers written in this application parts A & B and any supplements are complete and true to the best of my/our knowledge and belief, and it is agreed that:

A. This application and any supplement shall form the basis for and become a part of any policy issued.

B. The agent has no authority to waive the answer to any question in, or to modify, the application. No information will be considered to have been given to the company unless it is stated in the application, and that they will notify the company of any change in the statements or answers given between the time of the application and delivery of the policy.

C. The insurance applied for shall be in force as of the date of this application signed by me, provided that the Company approved the application without any modification as to plan, amount of premium, and, further provided that the Company receives the first premium payment from my employer within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance will become effective. If the application is approved with any such modification, the insurance shall not take effect until the policy has been delivered to and accepted by me.

D. The employee will be the owner unless otherwise stated in Remarks #30. In the event of the employee's death, ownership will transfer to the primary beneficiary unless a contingent owner is designated.

E. I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report 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. Upon request, I may be informed as to whether a consumer report was requested, and if such report was requested, I will be informed of the name and address of the consumer reporting agency that furnished the report. If the use of a consumer report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual Life Insurance Company of my rights, under the FCRA concerning that action.

F. I acknowledge that I have received a copy of Boston Mutual Life Insurance Company's Notice of Privacy Practices.

G. FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Employee *(Owner)* _____ Signature of Spouse *(If required by State law)* _____

Signature of Dependent Children *(If required by State law)* _____

Agent's statement: To the best of your knowledge, does this insurance replace or change any existing insurance or annuities? ❑ Yes ❑ No

Witnessed *(Licensed Agent)* _____ Signed state _____ Date ____/____/____

Print Licensed Agent Name _____ NPN # _____

You have the right to designate a third party for your policy. If designated, the policy owner and the designated third party will be notified of possible cancellation of the policy. I hereby designate the following person as a third party:

Name, Address and Telephone # of Third Party: _____

Important Notice: Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement. You should carefully consider whether a replacement is in your best interest. You will pay acquisitions costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing *(include the name of the insurer, the insured, and the contract number if available)* and whether each policy will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.				

Make sure you know the facts. Contact your existing company or its agents for information about the old policy or contract. *(If you request one, an in-force illustration, policy summary, or available disclosure documents must be sent to you by the existing insurer.)* Ask for and retain all sales materials used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

_____

_____

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature	Printed Name	Date
Producer's Signature	Printed Name	Date

I do not want this notice read aloud to me. _____ *(Applicants must initial only if they do not want the notice read aloud.)*

Replacement of Life Insurance or Annuities...*cont.*

A replacement may not be in your best interest, or your decision could be a good one.You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract.One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense.

PREMIUMS:

Are they affordable?

Could they change?

You're older - are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.
(Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.)

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST-SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? *(See your tax advisor.)*

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

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, 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 member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's 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.

BOSTON MUTUAL LIFE INSURANCE COMPANY
AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION
(This authorization complies with the HIPAA Privacy Rule)

I authorize any health plan, insurer, physician, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, services, or payment to the Proposed Insured/s, or on their behalf, as well as the MIB, Inc. *(formally known as the Medical Information Bureau, Inc.)* and other medical information providers, to disclose the entire medical record and any other Protected Health Information concerning such person to the Boston Mutual Life Insurance Company (BML), its employees and representatives. This authorization specifically includes the release of all information related to my health or that of my minor children and or my minor children's insurance policies and claims, including but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco, but excludes psychotherapy notes. The Protected Health Information is being disclosed so that BML may: 1) underwrite/assess an applicant's eligibility for coverage, 2) obtain reinsurance, 3) pay claims and, 4) conduct other legally permissible activities related to the coverage applied for by this individual. The time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. A copy of this authorization is as valid as the original. I understand that: I or my authorized representative have the right to revoke this authorization at any time by sending a written request for revocation. Revoking or failing to sign this Authorization may impair BML's ability to process this application; a revocation is not effective to the extent that the Authorization has been relied on for the above listed uses; any information disclosed pursuant to this authorization may be redisclosed and rediscloseed information may no longer be covered by federal rules governing privacy or health information. I acknowledge that I have received a copy of BML's Notice of Privacy Practices. I have read this Authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Primary Proposed Insured _____ Date _____

Spouse Signature Card

The Spouse Signature Card is sent home with the employee to obtain additional signatures where required. The card is a postage paid mailer that can be either returned to the enroller during the enrollment or mailed to the home office.

Example of Signature Card:

I understand that an application for insurance has been submitted to Boston Mutual Life Insurance Company and I consent to being insured.

Case Number_____

Employer Name_____

Employee Name (please print)_____

Insured Spouse's Name
Or Dependents: (please print) Age

_____
Signature of Insured Spouse or Dependent

Return this signed card to:

Boston Mutual Life Insurance Company
120 Royall ST * Canton, MA 02021

ESO-110 10/00 **228-05-7/08**

Fold with return address on outside and tape closed- Please do not staple

NOTICE OF INFORMATION PRIVACY PRACTICES

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

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:*

- 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
- medical information – collected directly from you or with your authorization from medical providers and/or MIB, LLC, a medical information exchange.

1. As allowed by the FCRA, with permissible purpose and authorization, we may collect information from Consumer Reports we run on you (as Consumer Report is defined by the FCRA) using Consumer Reporting Agencies. We do not collect information using Investigative Consumer Reports, as Investigative Consumer Report is defined by the FCRA. We do not collect data using Consumer Credit Reports, as Credit Report is defined by the FCRA.

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
- MIB, LLC, a medical information exchange, in accordance with the law
- 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 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 to: Boston Mutual Life Insurance Company Attention: Privacy Office, 120 Royall Street, Canton, MA 02021

Within 30 days of receipt of your written request for access to your records with us, we will provide you with a copy of your records, or access to your records and with whom they were shared, excluding any medical and psychological records involving conditions additionally protected by law. For those specific records, we will provide you with the name of the medical provider you may obtain them from. We may charge you a reasonable fee to cover the cost of providing copies of records to you. These records may be provided to you by another company we have contracted with.

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 information we have on file about you, based on your request. You must make the request in writing and state the reasons you are requesting the change to: Boston Mutual Life Insurance Company Attention: Privacy Office, 120 Royall Street, Canton, MA 02021.

Within 30 business days from the date of receipt of a written request to correct, amend or delete information we hold about you, we will review the request and the disputed information will be reviewed and reinvestigated. Upon the completion of the reinvestigation we, or our contracted Insurance Support Organization*, shall correct, amend or delete the portions in dispute and supply the correct information to any contracted insurance support organization that it may have been shared with within the past 7 years if applicable;
OR
Notify you of Boston Mutual's reason for refusal to correct, amend or delete the information; your right to file a statement with us; and your right to request a review by the MA Insurance Commissioner.

** Insurance Support Organization does not include Consumer Reporting Agencies.*

ADVERSE UNDERWRITING DECISIONS

In the event of an adverse underwriting decision, we will either provide you with the specific reason for the adverse underwriting decision or advise you that you may receive the specific reason. Upon the insurer's receipt of a written request within 90 business days from the date of the mailing of the adverse underwriting decision to the applicant, we will furnish within 21 business days from the date of receipt of such written request, the specific reason for the adverse underwriting decision, if not initially furnished, along with the specific items that support such decision, unless the documents are privileged and relate to the applicant's involvement in a criminal activity, fraud or material misrepresentation. These documents will be made available for review by the MA Insurance Commissioner, as needed. We will also not provide you with any medical or psychological records involving conditions additionally protected by law, but will supply such records upon our contacting and obtaining written approval from the medical provider. We will also supply these records directly to a qualified medical provider of the applicant's choice in writing to us. Additionally, if the adverse decision involves medical information received from MIB, LLC. or other information received from a Consumer Reporting Agency, we will inform you of any additional rights and how to contact these sources.

CONTACT INFORMATION

As cited in other sections of this Notice, our contact information is:

Boston Mutual Life Insurance Company
Attention – Privacy Office
120 Royall Street - Canton, MA 02021

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 Royall Street • Canton, MA 02021 • T: 781.770.0204 • F: 781.770.0487 • www.bostonmutual.com

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Workplace Solutions Case Transmittal

Please submit with applications to:
Boston Mutual Life Insurance Company
Attn: Issue Department
120 Royall Street
Canton, MA 02021

Case Information:

Agency Name: _____ Agency #: _____

Agency Contact Name/Phone#: _____

Case Name:_____ Case Number: _____

Issue Date: _____ First Deduction: _____Pay Frequency_____

This is a:

☐ New case ☐ Reenrollment ☐ Additional Apps ☐ Ongoing Enrollment (new hires)

	Whole Life	STD	LTD	CI	Accident
Total# Applications/Enrollment Forms submitted:	_____	_____	_____	_____	_____
Total# of Annual Premium	$_____	$_____	$_____	$_____	$ _____

	ER Life	Vol Term Life	Vol STD	Vol LTD	Other_____
Total# Applications/Enrollment Forms submitted:	_____	_____	_____	_____	_____
Total# of Annual Premium	$_____	$_____	$_____	$_____	$ _____

Total # of EOI Forms *(if applicable)*: _____

Signature: _____ **Date:** _____

BOSTON MUTUAL
LIFE INSURANCE COMPANY
– 1891–

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Case Name: _____ **Case #:** _____

List employee, spouse, and or dependent applying for an individual policy in alphabetical order.	Employee = E Dependent = D	ELOP Weekly Premium	EAOP/GAC Weekly Premium	ECIO/ECIP Weekly Premium	EDO/EDOP Weekly Premium	Other Weekly Premium

ELOP Weekly Premium X 52 _____ Annualized

EAOP/GAC Weekly Premium X 52 _____ Annualized

ECIO/ECIP Weekly Premium X 52 _____ Annualized

EDO/EDOP Weekly Premium X 52 _____ Annualized

Other _____ Weekly Premium X 52 _____ Annualized

BOSTON MUTUAL LIFE INSURANCE COMPANY

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

FAMILY MATTERS. NO MATTER WHAT.

LIFE CLAIM KIT
FOR PROCESSING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS

INSTRUCTIONS FOR FILING A LIFE CLAIM

On behalf of Boston Mutual Life Insurance Company, please accept our sincere condolences for your loss. We realize that this is a difficult time for you and your family and we will make every effort to process your claim promptly.

To expedite the processing of your claim, it is important that you submit all of the necessary information requested below.

1. The claim form should be fully completed by the named beneficiary or their authorized representative and signed where indicated. If more than one named beneficiary, please use the Additional Beneficiary form.
2. A clear photocopy of the death certificate for the insured.
3. The insurance policy. If the policy cannot be found, please complete the lost policy section of the claim form.
4. If claim is being made for accidental death benefits, the named beneficiary must also complete the Accidental Death Claim form. Applicable police and accident reports should also be attached.
5. If the coverage was paid for in full or in part by the Employer, or if this is group coverage and the Employer maintains the enrollment forms, an authorized representative of the employer must complete the Employer's Statement. All original enrollment forms and beneficiary changes must also be included with the claim.
6. Each beneficiary should complete the Life Insurance Payment Options form.
7. A HIPAA - Compliant authorization form should be completed by the named beneficiary *(or next of kin if named beneficiary is not next of kin)* if the coverage has been inforce less than two years.
8. If proceeds are assigned to a funeral home, we must be provided with the assignment form and the funeral bill if required by state.
9. Please read the "Fraud Warning Notice" for your state.
10. If you are a California consumer, please visit our website at www.bostonmutual.com for our California privacy notice.

*** * * Policies that have been in force less than two years could be contestable * * ***

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

BOSTON MUTUAL LIFE INSURANCE COMPANY

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

FAMILY MATTERS. NO MATTER WHAT.

LIFE CLAIM FORM

Policy Numbers of the Company under which claim is made by the undersigned

#1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Full Name of Insured _____ Married ☐ Widowed ☐

Address _____ Single ☐ Divorced ☐

Is Insured Known by any other name? YES ☐ NO ☐ If YES, please advise _____

Date of Birth _____ Date of Death _____ Soc. Sec. No. _____

Date Last Worked *(if known)* _____ Name of Employer _____

Please complete the following if Policy was in force less than 2 years and include a signed HIPAA-Compliant Authorization for the release of medical records.

Full Names and Addresses of all Physicians and Hospitals where insured was treated in last 5 years

	Name	Address	Telephone No.
1.			
2.			
3.			

BENEFICIARY'S INFORMATION

Beneficiary's Name _____ Beneficiary's Social Security No. _____

Beneficiary's Date of Birth _____ Beneficiary's Telephone No. _____ Beneficiary's Relationship _____

Beneficiary's Address _____

Beneficiary's Mailing Address *(if different)* _____

CERTIFICATION – 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 "Fraud Warning Notices" insert for your state.

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

STATEMENT OF POLICY LOSS *(To be completed only if original policy could not be found after a thorough search)*

Insured _____ Policy No _____

This policy was lost or destroyed. If the policy is found later, I agree to surrender it to the company without claim.

X _____ _____ _____
Signature of Beneficiary | Date | Signature of Witness

BOSTON MUTUAL LIFE INSURANCE COMPANY

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ACCIDENTAL DEATH CLAIM FORM

Beneficiary must fully complete this section if claiming Accidental Death Benefit

Insured's Name: _____

Date and time of accident causing death: Place of Death: Highway ☐ Home ☐ Work ☐

Date: _____ 20____ AM ☐ PM ☐ Recreation ☐ Other ☐ _____

Describe Accident in detail: ***(Please send copies of police reports, newspaper articles etc. to help in the processing of this claim)***

_____

_____

_____

_____

_____

Names of PHYSICIANS and HOSPITALS where Insured received treatment

Name	Address

Was an Autopsy Performed? YES ☐ NO ☐ If YES, by whom, where and date.

Name	Address	Date

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X _____ _____ _____

Signature of Beneficiary | Printed Name | Date

BOSTON MUTUAL LIFE INSURANCE COMPANY

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EMPLOYER'S STATEMENT

This form must be completed by an authorized representative of the Employer if the coverage was paid for in full or in part by the Employer, or if this is group coverage and the Employer maintains the enrollment forms.

LIFE CLAIM

Name of Insured: _____ Group Policy No: _____ Div. _____

Is Insured known by any other name: YES ☐ NO ☐ If YES, please advise: _____

Address of Insured: _____ Certificate No: _____

Date Insured Last Worked: _____ Date of Death: _____ Amount of Insurance: _____

No. of Hours worked each week: _____ Annual Earnings as of date last worked: _____

Reason for leaving work: Disability ☐ Resignation ☐ Vacation ☐ Leave of Absence ☐ Retired ☐
Lay Off ☐ Dismissed ☐ Other ☐ *(Specify)* _____

Was Insured an Employee at time of death? YES ☐ NO ☐ Insured's Occupation: _____

Date Employed: _____ Date of Birth: _____ Effective Date of Insurance: _____

Was Insurance terminated prior to death? YES ☐ NO ☐ If YES, date of termination and reason: _____

DEPENDENT LIFE CLAIM

Name of Dependent: _____ Date of Birth: _____ Date of Death: _____

Address of Dependent: _____
Street City/Town State Zip

Was Insurance terminated prior to death? YES ☐ NO ☐ If YES, date of termination and reason: _____

I hereby certify that the date through which premium for this Insured has been paid is: _____
Month/Day/Year

CERTIFICATION – 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 "Fraud Warning Notices" insert for your state.

X _____ _____
Signature of Authorized Representative Street City/Town State Zip

_____ _____
Employer Area Code Telephone Ext.

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ADDITIONAL BENEFICIARY STATEMENT

(To be completed if there is more than one beneficiary)

Name of Insured: _____ **Policy #:** _____

Beneficiary's Name: _____ Beneficiary's Social Security # _____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

CERTIFICATION – 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 "Fraud Warning Notices" insert for your state.

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

Beneficiary's Name: _____ Beneficiary's Social Security # _____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

CERTIFICATION – 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 "Fraud Warning Notices" insert for your state.

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

Beneficiary's Name: _____ Beneficiary's Social Security # _____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

CERTIFICATION – 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 "Fraud Warning Notices" insert for your state.

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

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LIFE INSURANCE PAYMENT OPTIONS

Please review the following payment options and select your option by checking the appropriate box and signing this form. Payment options may vary based on the policy selected. Please consult the policy for available options. If you have any questions or would like to discuss other payment options, please call our Claim Services team at 1-877-212-2950. Please return this form with your claim.

☐ **Lump sum payment.** By choosing this option, you are electing to receive the proceeds due in one lump sum payment. *(This is the most common payment option)*

☐ **Sum Payable as monthly income for a fixed number of years.** By choosing this option, you are electing to leave the Sum Payable with Boston Mutual Life Insurance Company. You will receive a monthly income for up to 20 years. We will pay an income once a month for the number of years chosen and the first payment will begin one month after the payment option date. Please circle the number of years you wish to receive this monthly income. The monthly income will be the payment amount for each $1,000 of sum payable next to the number of years chosen. We will pay interest on the amount left with us at a rate of at least 2 ½% per year.

MONTHLY PAYMENT FOR EACH $1,000 OF SUM PAYABLE

YEARS	PAYMENT	YEARS	PAYMENT
1	84.28	11	8.64
2	42.66	12	8.02
3	28.79	13	7.49
4	21.86	14	7.03
5	17.70	15	6.64
6	14.93	16	6.30
7	12.95	17	6.00
8	11.47	18	5.73
9	10.32	19	5.49
10	9.39	20	5.27

☐ **Interest Income.** By choosing this option, you are electing to leave the Sum Payable with Boston Mutual Life Insurance Company. We will pay interest on the amount left on deposit at a rate of at least 2 ½ % per year. The interest will be paid once a year and the first payment will be issued one year after the Payment Option Date. You may choose the number of years, up to 15 years, to receive the interest income. The payee may withdraw all or a part of the Sum Payable at any time, but may not withdraw any amount if less than $1,000 will be left with us. In this case, the payee must withdraw the full amount. Please advise the number of years _____.

☐ **Sum Payable as monthly income of a fixed amount.** By choosing this option, you are electing to leave the Sum Payable with Boston Mutual Life Insurance Company and choosing, subject to our consent, an amount of monthly income that you will receive. Monthly payments must be at least $5.00 for each $1000 of Sum Payable. The first payment will begin as of the payment option date. We will credit interest on the balance of the Sum Payable left with us. This interest will be a rate of at least 2 ½% a year, compounded once a year. Payment will last until the Sum Payable, plus interest runs out.

Date

X
Signature of Beneficiary

Printed Name

Insured's Name

*** Interest earned on the Sum Payable left with Boston Mutual Life Insurance Company may be taxable. Please consult your tax advisor ***

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 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.

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

BOSTON MUTUAL LIFE INSURANCE COMPANY – 120 Royall Street | Canton, MA 02021 | 800.669.2668 | www.bostonmutual.com

916-737 1/17

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.

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

BOSTON MUTUAL LIFE INSURANCE COMPANY -1891-

FAMILY MATTERS. NO MATTER WHAT.®

LIFE INSURANCE COMPANY OF BOSTON&NEW YORK

FAMILY MATTERS. NO MATTER WHAT.®

Commission Distribution Form

Agency Name:

Agency Number:

Case Name:

Issue Date:

Case Numbers :

**Case number(s) to be filled out by designated IC*

Commission Info

Commissions are paid as earned and are based off a percentage of the monthly premium of each policy. Commission percentage can be split up to 3 agents per case. If the bonus and/or convention split differs from the commission split please advise in "comments"section below.

Agent	% of Commission	Comments (optional)
1.)		
2.)		
3.)		

The commission splits above are for the following lines of business.(Mark with X)

Employee Life Option Plus ____ Employee Disability Option Plus ____ Employee Critical Illness Plus ____ Employee Accident Option Plus ____ Group Accident ____

***Please fill out an additional Commission Distribution Form if two separate lines of business are paying different commission splits for the same issue date.*

By signing below, you are acknowledging the information in the chart above is the final commission set up the case. If the splits change at a later issue date, a new Commission Distribution Form is needed.

Signature:_____ Date:_____