MassMutual

HIPAA Authorization

For use with Life, DI & Life with Long Term Care Riders

This Authorization complies with HIPAA Privacy Rule. "HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended. "I", "you" and "your" refer to the Proposed Insured or Insured.

A Authorizations

- I hereby authorize the use and disclosure of my medical records, medical history and other information that relates to the diagnosis, treatment or prognosis of any physical or mental condition, whether in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs and pharmaceutical records; diagnostic testing; laboratory records; alcohol or drug use; and communicable or infectious diseases or conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases unless otherwise restricted by state law.
- This Authorization specifically excludes psychotherapy notes. Psychotherapy notes means notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session, and that are separated from the rest of any individual's medical record. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop dates, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date; therefore, such medical records are covered by this Authorization.
- I hereby authorize the following persons or entities who have provided payment, treatment or services to me or on my behalf within the past ten (10) years to disclose all medical or health information about me: a physician; medical practitioner or health care professional or provider; hospital; clinic; laboratory; medical or medically-related facility; pharmacy or pharmacy benefit manager; health plan. I further authorize the following persons or entities to disclose all medical or health information about me: any insurance company, including the Company ("Company" as referred to herein, is Massachusetts Mutual Life Insurance Company, and/or MML Bay State Life Insurance Company and/or C.M. Life Insurance Company), or reinsurance company; any consumer reporting agency such as the MIB, Inc. ("MIB"); the Department of Motor Vehicles or any other state or federal government agency; and/or any other organization, institution or person having personal health information about me.
- I hereby authorize the disclosure of my medical or health information to the Company, its service providers, its reinsurers and its agents, representatives and insurance producers (including the agents, representatives and employees of such persons or entities). I hereby authorize the disclosure of my medical or health information to any consumer reporting agency, including the MIB.
- I hereby authorize the use and disclosure of my medical or health information for purposes of and in connection with underwriting my application for insurance with the Company, determining the premium for the insurance, obtaining reinsurance, servicing my insurance and administering coverage, evaluating any claim for insurance benefits and conducting other legally permissible activities that relate to any coverage I have applied for. I understand that there may be additional uses or disclosures of my medical or health information that are specifically permitted by law without my Authorization, such as to government regulatory or law enforcement entities.

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

B Agreements & Signatures

If I do not sign this Authorization, the Company may (i) decline my application for insurance or not be able to offer me any coverage and/or (ii) decline to pay a claim for benefits under any insurance issued. Providers of health care services or medical treatment may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.

My Authorization may be revoked by sending a written request to:

MassMutual
Attn: Authorization Administrator – Underwriting Dept.
1295 State Street
Springfield, MA 01111-0001

I may not revoke any Authorization that was obtained as a condition of obtaining insurance, paying a claim, or that was relied or acted upon.

This Authorization applies to my entire medical record. Any agreements I have made to restrict my medical or health information do not apply to this Authorization.

My health information may be re-disclosed and no longer protected by HIPAA if the person receiving this information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers providing long-term care insurance and health care providers. However, the Company requires its employees, agents, representatives, insurance producers and service providers to protect the confidentiality of health information regardless of whether the employee, agent, representative, insurance producer or service provider is engaged in an insurance business subject to HIPAA. Information may only be re-disclosed in accordance with applicable laws or regulations.

This Authorization shall be valid for twenty-four (24) months from the date I sign it. A copy or facsimile of this Authorization may be relied upon as if it were an original.

I, or the Representative authorized to act on my behalf, have received a copy of this Authorization.

Some states' rules concerning Authorizations change the terms and provisions of this Authorization. By signing below, you acknowledge the conditions identified on page three are considered part of this Authorization and apply in the identified states.

Signature *(Required for all cases)*

Signature of Proposed Insured/Insured/Representative: _____

Printed name: _____ Date: _____

Proposed Insured/Insured's full legal name *(If different than above):* _____

Proposed Insured/Insured's date of birth *(mm/dd/yyyy):* _____

Relationship to Proposed Insured/Insured *(If Representative):* _____

C State-Specific Authorizations

If you reside in a state listed below, then the identified provisions apply to your Authorization.

- **ARIZONA.** With respect to disclosure of HIV-related information only, this Authorization is valid for 180 days from the date it is signed.
- **MAINE.** This Authorization excludes the disclosure of the result of a test for HIV if the Proposed Insured or Insured has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat shall otherwise prohibit this Authorization from including other facts and information relative to the fact that the Proposed Insured or Insured has AIDS.
- **MINNESOTA.** This Authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency personnel who were tested as a result of performing emergency medical services. The term **"emergency medical personnel"** includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.
- **NEW MEXICO.** "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant, proposed insured or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant, proposed insured or insured is known to have a direct, close personal, family or abuse-related counseling relationship. During the time this Authorization is valid it extends to the information required to determine eligibility for benefits under any policy issued as a result of this application.

  With respect to confidential abuse information, this Authorization may be revoked in writing, ten days after receipt by the Company, but doing so may result in an application or claim being denied or may otherwise adversely affect a pending insurance action.

  The Company may collect genetic information about you for use in conducting and administering its business of insurance. "Genetic information" means the information about a genetic makeup of a person or members of a person's family, including information resulting from genetic testing, genetic analysis, DNA composition, participation in genetic research or use of genetic services. This information may only be used, transmitted or retained for the purpose of conducting and administering its business of insurance, except with your consent or as otherwise authorized or required by law.
- **OREGON.** With respect to disclosure of HIV-related information only, this Authorization is valid for 180 days from the date it is signed.
- **VERMONT.** This Authorization does not extend to previously administered test for HIV antibodies, T-Cell counts, AIDS or ARC, nor to any medical doctor, doctor of osteopathy, physician, health care professional, hospital, clinic, medical facility, the Veterans Administration, the MIB Inc., employer, consumer reporting agencies, other insurance company, or anyone else, with respect to previous test results. I am not providing authorization for the release of results from any new test for the HIV virus to any outside, non-affiliated company nor to any company not under contract with the company to perform underwriting services.
- **VIRGINIA.** If this Authorization is used for claim purposes it is valid for the duration of the claim.

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- I hereby authorize the following persons or entities who have provided payment, treatment or services to me or on my behalf within the past ten (10) years to disclose all medical or health information about me: a physician; medical practitioner or health care professional or provider; hospital; clinic; laboratory; medical or medically-related facility; pharmacy or pharmacy benefit manager; health plan. I further authorize the following persons or entities to disclose all medical or health information about me: any insurance company, including the Company ("Company" as referred to herein, is Massachusetts Mutual Life Insurance Company, and/or MML Bay State Life Insurance Company and/or C.M. Life Insurance Company), or reinsurance company; any consumer reporting agency such as the MIB, Inc. ("MIB"); the Department of Motor Vehicles or any other state or federal government agency; and/or any other organization, institution or person having personal health information about me.
- I hereby authorize the disclosure of my medical or health information to the Company, its service providers, its reinsurers and its agents, representatives and insurance producers (including the agents, representatives and employees of such persons or entities). I hereby authorize the disclosure of my medical or health information to any consumer reporting agency, including the MIB.
- I hereby authorize the use and disclosure of my medical or health information for purposes of and in connection with underwriting my application for insurance with the Company, determining the premium for the insurance, obtaining reinsurance, servicing my insurance and administering coverage, evaluating any claim for insurance benefits and conducting other legally permissible activities that relate to any coverage I have applied for. I understand that there may be additional uses or disclosures of my medical or health information that are specifically permitted by law without my Authorization, such as to government regulatory or law enforcement entities.

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Signature *(Required for all cases)*

Signature of Proposed Insured/Insured/Representative: _____

Printed name: _____ Date: _____

Proposed Insured/Insured's full legal name *(If different than above):* _____

Proposed Insured/Insured's date of birth *(mm/dd/yyyy):* _____

Relationship to Proposed Insured/Insured *(If Representative):* _____

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- **MINNESOTA.** This Authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency personnel who were tested as a result of performing emergency medical services. The term **"emergency medical personnel"** includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.
- **NEW MEXICO.** "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant, proposed insured or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant, proposed insured or insured is known to have a direct, close personal, family or abuse-related counseling relationship. During the time this Authorization is valid it extends to the information required to determine eligibility for benefits under any policy issued as a result of this application.

  With respect to confidential abuse information, this Authorization may be revoked in writing, ten days after receipt by the Company, but doing so may result in an application or claim being denied or may otherwise adversely affect a pending insurance action.

  The Company may collect genetic information about you for use in conducting and administering its business of insurance. "Genetic information" means the information about a genetic makeup of a person or members of a person's family, including information resulting from genetic testing, genetic analysis, DNA composition, participation in genetic research or use of genetic services. This information may only be used, transmitted or retained for the purpose of conducting and administering its business of insurance, except with your consent or as otherwise authorized or required by law.
- **OREGON.** With respect to disclosure of HIV-related information only, this Authorization is valid for 180 days from the date it is signed.
- **VERMONT.** This Authorization does not extend to previously administered test for HIV antibodies, T-Cell counts, AIDS or ARC, nor to any medical doctor, doctor of osteopathy, physician, health care professional, hospital, clinic, medical facility, the Veterans Administration, the MIB Inc., employer, consumer reporting agencies, other insurance company, or anyone else, with respect to previous test results. I am not providing authorization for the release of results from any new test for the HIV virus to any outside, non-affiliated company nor to any company not under contract with the company to perform underwriting services.
- **VIRGINIA.** If this Authorization is used for claim purposes it is valid for the duration of the claim.

MassMutual

Application for Individual Life & Disability Insurance (Part 1)

The Insurer identified below will be referred to herein as the "Company":

Massachusetts Mutual Life Insurance Company

(MassMutual) 1295 State Street, Springfield, Massachusetts 01111-0001

If applying for *(Select all that apply):*		**Complete sections**
☐ Individual Life or Survivorship Life New Business		A-G & L-N
☐ Individual Disability Income New Business	Right to Apply #: _____	A-B & H-N

A Personal Information

Complete this section for the Proposed Insured.

1. Full legal name *(First, MI, Last, Suffix):* _____

2. Gender *(Select one):* ☐ Male ☐ Female

3. Date of birth *(mm/dd/yyyy):* _____

4. Place of birth *(Country & State/Province):* _____

5. Taxpayer Identification Number *(SSN/ITIN):* _____

6. Residential address – ***do not use PO Box*** *(Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):*

_____

_____

7. Mailing address – ***only if different than question 6*** *(PO Box or Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):*

_____

_____

8. Preferred phone number: (____) ____ - ____ Extension: _____ ☐ Home ☐ Work ☐ Mobile

Alternate phone number: (____) ____ - ____ Extension: _____ ☐ Home ☐ Work ☐ Mobile

Best time to call: _____ ☐ am ☐ pm

9. Email address: _____

10. U.S. Driver's License ***(If actual age under 16, skip to question 11):*** ☐ Yes ☐ No

If No *(Select one):* ☐ Passport ☐ Other *(Specify):* _____

a. Identification number: _____

b. State or Country of issue: _____

c. Expiration date *(mm/dd/yyyy):* _____ *Only required if Passport or Other*

11. Type of citizenship *(Select one):* ☐ Resident U.S. citizen ☐ Non-resident U.S. citizen ☐ Resident alien ☐ Non-resident alien

If U.S. citizen, skip to section B – Personal History Information. If alien, continue to question 11a and attach copy of visa.

a. Country of citizenship: _____

b. Type of visa: _____

c. Visa number: _____

d. Expiration date *(mm/dd/yyyy):* _____

B Personal History Information

1. Is the Proposed Insured currently disabled or applying for any disability benefits? ***If Yes, provide details in section L*** ☐ Yes ☐ No
2. Is this a Life conversion or Life insurability option exercise? ☐ Yes ☐ No

If Yes, answer questions 3-5 and use the Conversion & Insurability Option Supplement. In addition, if Evidence of Insurability is required, complete all questions below; otherwise, skip to section C – Life Product Information.

For questions 3-12, provide details for any Yes answers in section L – Additional Information.

Has the Proposed Insured:

3. Used tobacco or nicotine containing products except cigars (e.g. cigarettes, e-cigarettes, pipes, snuff, chewing tobacco or nicotine delivery device such as gum or the patch):
   - **a.** Within the last 12 months? ☐ Yes ☐ No
   - **b.** Within the last 24 months? ☐ Yes ☐ No
4. Used cigars within the last 24 months? ☐ Yes ☐ No

   If Yes, provide number of cigars per year: _____
5. Used a prescription medication to assist with smoking cessation or as a substitute for smoking (e.g. Chantix, Wellbutrin, etc.) within the last 12 months? ☐ Yes ☐ No
6. Ever been convicted of a felony, or currently on parole or probation? ☐ Yes ☐ No
7. Been convicted of operating a motor vehicle while under the influence of alcohol or drugs within the last 5 years? ☐ Yes ☐ No
8. Been in a motor vehicle accident in which they were found to be at fault, convicted of a moving violation or received a driver's license restriction or revocation within the last 3 years? ☐ Yes ☐ No

Does the Proposed Insured:

9. Have scheduled plans to travel outside the U.S., or has participated in travel outside the U.S. within the last 2 years? ***If Yes, use Foreign Travel Supplement*** ☐ Yes ☐ No
10. Have a written agreement to become, or is currently a member, of the Armed Forces? ***If Yes, use Military Supplement*** ☐ Yes ☐ No
11. Currently take classes or is enrolled in a course to become, a pilot, a student pilot or crew member of any aircraft, or has participated in these activities within the last 3 years? ***If Yes, use Aviation Supplement for Life*** ☐ Yes ☐ No
12. Take part in underwater diving, hang gliding, para sailing, para kiting, parachuting, skydiving, ultralight, soaring, ballooning, bungee jumping, rock or mountain climbing, helicopter skiing, or organized racing by automobile, motorcycle, motorboat or snowmobile, in the last 3 years or has scheduled plans to participate in these activities? ***If Yes, use Avocation Supplement*** ☐ Yes ☐ No
13. Primary physician/practice:
    - **a.** Full legal name *(If no current, physician seen in last 5 years):* _____
    - **b.** Business address *(Street, Suite #, City & State or Country, ZIP/Postal Code):* _____
    - **c.** Phone number: (_____) _____ - _____
    - **d.** Date last seen: _____
14. Current occupation: _____
    - **a.** Duties: _____
    - **b.** Employer/business name *(If self-employed, provide business name):* _____
    - **c.** Employer/business address *(PO Box or Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):* _____
15. Earned income *(If business owner, include share of business profit/loss in addition to wages):*
    - **a.** Current year: $ _____ **b.** Prior year: $ _____
16. Unearned income *(e.g. interest, dividends, capital gains, rents):*
    - **a.** Current year: $ _____ **b.** Prior year: $ _____

B Personal History Information *continued*

For Life, complete questions 17-19. For DI only, skip to section H – Disability Income Product Information.

17. Net worth: $ _____

18. If a student, retiree, homemaker, juvenile, unemployed or disabled *(For question 18d, include in force and applied for coverage):*

a. Annual household earned income: $ _____

b. Annual household unearned income: $ _____

c. Household net worth: $ _____

d. Other coverage on working spouse: $ _____

19. If juvenile, list all family members (including siblings, parents and legal guardians) in the table below. For the coverage columns, provide the total life insurance currently applied for or now in force with MassMutual or other companies. If none, explain in section L – Additional Information.

Relationship	Name	Age	Group Coverage	Non-Group Coverage
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$

C Life Product Information

Complete for all Life Products. Only one Primary may be selected per Application.

1. Maximum face amount being applied for on this Application: $ _____

Whole Life *(Select one):* ☐ Primary ☐ Alternate ☐ Additional ***For Survivorship, also use Additional Insured Supplement***

2. Plan: _____

3. Face amount: $ _____

4. Automatic Premium Loan (APL): ☐ Yes ☐ No

5. Loan rate *(Select one):* ☐ Adjustable ☐ Fixed

6. Dividend Option *(Select one):* ☐ Paid-up additions

☐ Cash ☐ Supplemental Insurance Dividend/Flex

☐ Dividend Accumulations

☐ Other *(Specify):* _____

Riders *(Not all riders are available on all plans)*

7. Waiver of Premium (for Disability) Rider:

☐ Insured 1 ☐ Insured 2

8. Waiver of Premium (upon Death of Specified Insured) Rider *(Survivorship only):* ☐ Insured 1 ☐ Insured 2

9. Accelerated Death Benefit for Long Term Care Services Rider (LTCR):

☐ Yes ☐ No ***If Yes, complete LTCR Application.***

10. Guaranteed Insurability Rider: $ _____

11. Renewable Term Rider: $ _____

12. Additional Life Insurance Rider (ALIR):

a. Modal Payment: $ _____

Number of years: _____

Paying all/part using 1035 funds?* ☐ Yes ☐ No

b. Planned ALIR: $ _____

Number of years: _____

Paying all/part using 1035 funds?* ☐ Yes ☐ No

c. Unscheduled Lump Sum: $ _____

Paying all/part using 1035 funds?* ☐ Yes ☐ No

d. Dividend Option *(Select one):*

☐ Same as base policy ☐ Paid-up Additions

13. Life Insurance Supplement Rider (LISR):

a. Face amount: $ _____

b. Modal Payment: $ _____

c. Unscheduled Lump Sum: $ _____

Paying all/part using 1035 funds?* ☐ Yes ☐ No

d. Premium Paying Period**: _____ years

e. Crossover Year**: _____ years

14. Estate Protection Rider *(Survivorship only):* ☐ Yes ☐ No

15. Other Rider *(Indicate type and amount):* _____

**The amount indicated above is an estimate of the 1035 exchange proceeds and will be changed once the actual amount available from the 1035 exchange is determined and money is received.*

***If not completed, the Premium Paying Period and Crossover Year will be set to equal the amount of years until Proposed Insured reaches age 100.*

C Life Product Information *continued*

Term Life *(Select one):* ☐ Primary ☐ Alternate ☐ Additional

16. Plan: _____

17. Face amount: $ _____

Riders *(Not all riders are available on all plans)*

18. Waiver of Premium (for Disability) Rider: ☐ Yes ☐ No

19. Other Rider *(Indicate type and amount):* _____

Variable or Universal Life *(Select one):* ☐ Primary ☐ Alternate ☐ Additional ***Additional forms are required for these products***

20. Plan: _____

21. Face amount: $ _____

22. Planned Premium: $ _____

23. Non-1035 unscheduled premium: $ _____

24. Loan rate: ☐ Fixed

25. Death Benefit Option *(Select one; not all Death Benefit Options are available for all plans):*

☐ Level

☐ Increasing by Account Value ***(If selected, continue to 25a)***

a. Schedule change from Increasing by Account Value to Level? ☐ Yes ☐ No

b. If Yes, schedule at attained age: _____

☐ Return of Premium

26. Definition of Life Insurance *(Select one):*

☐ Cash Value Accumulation Test

☐ Guideline Premium Test

Riders *(Not all riders are available on all plans)*

27. Rider options *(Select one):*

a. Waiver of Monthly Charges/Deductions: ☐ Yes ☐ No

b. Disability Benefit Rider: $ _____

c. Waiver of Specified Premium Rider: $ _____

28. Guaranteed Insurability Rider (GIR): ☐ Yes ☐ No

29. Other Rider *(Indicate type and amount):* _____

Other Alternate/Additional *(Select one):* ☐ Alternate ☐ Additional

If Alternate is selected, the Owner is applying for either the policy indicated in questions 1-29 or the policy indicated below. If Additional is selected, the Owner is applying for both the policy indicated in questions 1-29 and the policy indicated below.

30. Details/remarks *(Plan, face amount, riders, dividend options, etc.):* _____

D Life Purpose of Insurance

1. What is the purpose of the insurance? *(Select all that apply):*

a. Personal: ☐ Income for dependents ☐ Estate taxes ☐ Mortgage ☐ Future insurability ☐ Other: _____

b. Business ***(If any Business options are selected, use Business Life Insurance Supplement):***

☐ Key employee ☐ Stock redemption ☐ Cross purchase ☐ Loan guarantee coverage ☐ Other: _____

c. Split Dollar: ☐ Assignment ☐ Endorsement

2. Is this policy being purchased in connection with an employer-sponsored plan? ☐ Yes ☐ No

a. If Yes, provide type *(Select one):* ☐ Tax qualified ☐ Non-qualified

b. If Non-qualified, will the policy be issued on a Unisex basis? ☐ Yes ☐ No

3. Will this policy be collaterally assigned? ☐ Yes ☐ No

4. Has the Proposed Insured(s) and/or the Proposed Policy Owner(s) been offered any economic incentive such as "free" life insurance or money to purchase this policy or entered into any arrangement that entitles a lender or investor to any portion of the death benefit beyond a loan repayment? ☐ Yes ☐ No

5. Does the Proposed Insured(s) and/or the Proposed Policy Owner(s) have a current agreement or commitment to sell, transfer, assign, or release this policy – or any beneficial interest of this policy or its ownership structure – to a life settlement company, viatical company, bank, investor or secondary market provider? ☐ Yes ☐ No

6. Is this policy directly or indirectly owned by a captive insurance company? ☐ Yes ☐ No

7. Will the source of any premium payments be assets of or from contributions to a captive insurance company? ☐ Yes ☐ No

E Life Owner & Beneficiary Information

1. Ownership arrangement *(Select one):*

☐ Proposed Insured is the only Owner/Proposed Insureds *(if survivorship)* are the only Owners

☐ Other ***(If selected, provide Proposed Owner name(s) below and use Owner Designation Form):***

Name(s) of Proposed Owner(s): _____

_____

2. Beneficiary arrangement *(Select one):*

☐ Sole Individual Primary/Sole Individual Secondary Beneficiary ***(If selected, complete the table below)***

☐ Other, including UTMA/UGMA ***(If selected, use Beneficiary Designation Form and skip to section F)***

Primary

Full legal name: _____

Mailing address: _____

Preferred phone number: (___) ___ - ___ Ext: ___ ☐ Home ☐ Work ☐ Mobile ☐ Unknown

Date of birth *(mm/dd/yyyy):* _____ TIN: _____ ☐ SSN ☐ EIN ☐ Unknown

Relationship to Insured: _____ Distribution: 100%

Secondary/Contingent

Full legal name: _____

Mailing address: _____

Preferred phone number: (___) ___ - ___ Ext: ___ ☐ Home ☐ Work ☐ Mobile ☐ Unknown

Date of birth *(mm/dd/yyyy):* _____ TIN: _____ ☐ SSN ☐ EIN ☐ Unknown

Relationship to Insured: _____ Distribution: 100%

F Life Other Coverage/Replacement Information

1. Total amount of non-Group life insurance currently **applied for** with MassMutual or other companies: $ _____

2. Total amount of non-Group new insurance that will be **placed** in all companies: $ _____

3. Total amount of non-Group life insurance currently **in force** with MassMutual or other companies, including any policies which may have been sold, transferred or assigned *(If none, enter 0):* $ _____

4. Does the Proposed Insured have non-Group life insurance or annuity contracts currently in force, pending, applied for, or conditionally issued **with other companies** (excluding MassMutual) that are **not** being replaced/changed*? ***If Yes, complete the table below.*** ☐ Yes ☐ No

5. Is this Application intended to replace/change* any Group or non-Group life insurance or annuity contract in force **with MassMutual or other companies**? ***If Yes, complete the table below and use the state appropriate replacement form(s).*** ☐ Yes ☐ No

**Replace/change means within 13 months, causing a policy/contract to lapse, surrender (in whole or part), forfeit, terminate, convert to reduced paid up or continue as extended term insurance, reduce in value by borrowing against it, change the term or coverage benefits.*

Policy Number & Company	Face Amount	Product	Issue Yr.	Purpose	Status	Replace	1035x
	$			☐ Business ☐ Personal	☐ Applied for ☐ In force	☐ Yes ☐ No	☐ Yes ☐ No
	$			☐ Business ☐ Personal	☐ Applied for ☐ In force	☐ Yes ☐ No	☐ Yes ☐ No
	$			☐ Business ☐ Personal	☐ Applied for ☐ In force	☐ Yes ☐ No	☐ Yes ☐ No
	$			☐ Business ☐ Personal	☐ Applied for ☐ In force	☐ Yes ☐ No	☐ Yes ☐ No

F Life Other Coverage/Replacement Information *continued*

For 1035 Exchanges, complete questions 6-8 and use applicable 1035 Exchange forms. Otherwise, skip to question 9.

6. Anticipated value of exchange: $ _____

7. Apply 1035 Exchange proceeds to *(Select all that apply):* ☐ Additional premium *(UL or VL)* ☐ ALIR ☐ LISR ☐ Initial premium

8. Will a policy loan be carried over to the new policy? ☐ Yes ☐ No

For Internal Term to Term Replacements, complete question 9. Otherwise, skip to section G – Life Payment Information.

9. Do you wish to terminate an existing internal term policy or rider? ☐ Yes ☐ No ***If Yes, use Term to Term Replacement Form.***

G Life Payment Information

1. Billing type *(Select one):* ☐ Pre-Authorized Check *(PAC;* ***if selected, use applicable PAC form****)* ☐ Individual Direct Bill
☐ Group Bill with Invoice/Franchise number ***(Must be provided at the time of business submission):*** _____

2. Frequency *(Select one):* ☐ Monthly *(PAC/Group only)* ☐ Quarterly ☐ Semi-annual ☐ Annual ☐ Single Premium *(If available)*

3. Is initial premium being submitted with this Application? ☐ Yes ☐ No ***If Yes, use Temporary Life Insurance Receipt***

4. Save age *(If Yes, premium will be due for each month Policy is backdated to save age):* ☐ Yes ☐ No

5. Policy dating *(Select one):* ☐ Date of issue ☐ Specific date *(Up to the 28th of each month):* _____

6. Source of Premium *(Select all that apply):* ☐ Earned Income ☐ Investment Income ☐ Investment/Savings
☐ Gifts/Inheritance ☐ Loan/Premium Financing ☐ Other *(Specify):* _____

7. Premium Payor *(Select one):* ☐ Proposed Insured(s) ☐ Proposed Owner(s) ☐ Other

If Other is selected, provide details in questions 7a-7b.

a. Full legal name *(First, MI, Last, Suffix):* _____

b. Mailing address *(PO Box or Street, Apt. or Suite #, City & State or Country, Zip/Postal Code):*

_____

_____

H Disability Income Product Information

Complete for Radius Choice or Radius. Not all Riders, Endorsements, Benefit Periods and Elimination Periods are available with all products.

1. Base Policy:

a. Product name: _____

b. Monthly Benefit: $ _____

c. Benefit Period: ☐ 2 years ☐ 5 years ☐ 10 years
☐ To Age 65 ☐ To Age 67 ☐ To Age 70

d. Elimination Period: ☐ 60 days ☐ 90 days
☐ 180 days ☐ 365 days ☐ 730 days

Recipient of Benefits Assignment:

Full legal name *(First, MI, Last, Suffix):*

_____

_____

Relationship: _____

Taxpayer Identification Number *(SSN/ITIN):*

_____

2. Other Benefits & Riders:

☐ Social Insurance Rider *(Elimination Period and Benefit Period must be same as Base Policy)*
Monthly Benefit: $ _____

☐ Extended Partial Disability Benefits Rider *(Elimination Period and Benefit Period must be same as Base Policy. Must be issued with a Radius or Radius Choice policy.)*

☐ Automatic Benefit Increase Rider

☐ Catastrophic Disability Benefit Rider:
Monthly Benefit: $ _____
Benefit Period: ☐ 2 years ☐ 5 years ☐ 10 years
☐ To Age 65 ☐ To Age 67 ☐ To Age 70
Elimination Period: ☐ 60 days ☐ 90 days
☐ 180 days ☐ 365 days ☐ 730 days

☐ Cost of Living Rider

☐ Own Occupation Rider *(Not available with Group Supplement Coverage B or Short Term Disability Benefit Rider)*

☐ Future Insurability Option Rider (FIO):
Amount: $ _____
Option month *(If different from Anniversary):* _____

☐ Benefit Increase Rider *(Not available if FIO is elected)*

H Disability Income Product Information *continued*

☐ Short Term Disability Benefits Rider 1:

Monthly Benefit: $ _____

Elimination Period/Benefit Period *(Select one):*

☐ 60 day Elimination Period/4 month Benefit Period

☐ 90 day Elimination Period/3 month Benefit Period

☐ Short Term Disability Benefit Rider 2:

Monthly Benefit: $ _____

180 day Elimination Period/6 month Benefit Period

☐ Group Supplement Disability Benefits Rider *(Elimination Period can be equal to or greater than Base Policy)*

☐ Coverage A:

Monthly Benefit: $ _____

Benefit Period: ☐ 10 years ☐ To Age 65 ☐ To Age 67

Elimination Period: ☐ 60 days ☐ 90 days

☐ 180 days ☐ 365 days ☐ 730 days

☐ Coverage B *(Not available if Own Occupation Rider is elected):*

Monthly Benefit: $ _____

Benefit Period: ☐ 10 years ☐ To Age 65 ☐ To Age 67

Elimination Period: ☐ 60 days ☐ 90 days

☐ 180 days ☐ 365 days ☐ 730 days

☐ HIV Disability Rider:

Monthly Benefit: $ _____

No Elimination Period/24 month maximum Benefit Period

☐ RetireGuard Rider:

Monthly Benefit: $ _____

Benefit Period: ☐ 10 years ☐ To Age 65 ☐ To Age 67

Elimination Period: ☐ 180 days ☐ 365 days

Amount of Contribution: $ _____

Frequency: ☐ Annual ☐ Monthly

Employer amount: $ _____

Employee amount: $ _____

Recipient of Benefits Assignment:

Full legal name *(First, MI, Last, Suffix):*

_____

_____

Taxpayer Identification Number *(SSN/ITIN):*

_____

☐ RetireGuard Future Insurability Option (FIO):

Amount: $ _____

Option month *(If different from Anniversary):* _____

☐ RetireGuard Cost of Living Option (COLA)

☐ Student Loan Rider ***(Use Student Loan Rider Supplement)***

Maximum Monthly Benefit: $ _____

Elimination Period: ☐ 90 days ☐ 180 days

Coverage Term: ☐ 10 years ☐ 15 years

Complete for RetireGuard Standalone *(Complete for Radius Choice or Radius)*

3. Is policy applied for being issued as RetireGuard?

☐ Yes ☐ No

If Yes, continue to question 3a. If No, skip to question 7.

a. Product name: _____

b. Monthly Benefit: $ _____

c. Benefit Period: ☐ 10 years ☐ To Age 65 ☐ To Age 67

d. Elimination Period: ☐ 180 days ☐ 365 days

4. Amount of Contribution: $ _____

Frequency: ☐ Annual ☐ Monthly

Employer amount: $ _____

Employee amount: $ _____

5. Options *(Select all that apply):*

☐ RetireGuard Cost of Living Option (COLA)

☐ RetireGuard Future Insurability Option (FIO) ***If selected:***

Amount: $ _____

Option month *(If different from Anniversary):* _____

6. Recipient of Benefits Assignment:

Full legal name *(First, MI, Last, Suffix):*

_____

_____

Taxpayer Identification Number *(SSN/ITIN):*

_____

Complete for Age 61 Plus *(2 Year Benefit Period Only)*

7. Monthly Benefit: $ _____ Elimination Period: ☐ 60 days ☐ 90 days ☐ 180 days

Additional Products

☐ Business Overhead Expense – ***Complete Business Overhead Expense Supplement***

I Disability Income Employment Information

1. What percent of the Proposed Insured's duties include physical activity such as climbing, crouching, lifting, etc? _____ %
2. State Proposed Insured works in: _____
3. How long has the Proposed Insured been employed with his or her current employer? _____ years

   If less than 2 years, complete questions 3a-3b.

   a. Previous occupation: _____ **b.** Duration: _____ years
4. How many hours per week, on average, does the Proposed Insured work in his or her occupation? _____
5. For the past 90 days, have you been continuously at work in your primary occupation without limitation due to injury or sickness?
   ☐ Yes ☐ No

   If Yes, skip to section J – Disability Income Payment Information. If No, complete questions 5a-5b.

   a. How many full or partial days during the specified period above has the Proposed Insured missed work due to sickness or injury?

   b. Provide dates and details for any days of work missed, reduced work hours, or job restriction or modifications due to injury or sickness during the specified period above: _____

J Disability Income Payment Information

1. Does the Proposed Insured's net worth exceed $10,000,000? ☐ Yes ☐ No
2. Proposed Insured's employment relationship *(Select one):* ☐ Employee (No Ownership Interest)

   If an item from the group below is selected, complete questions 2a-2b.

   ☐ Sole Proprietor ☐ Partner in Partnership ☐ Shareholder in Sub "S" Corporation ☐ Owner of C-Corporation

   ☐ Owner of Limited Liability Company. *If selected, provide tax form filed:* _____

   a. Percent of ownership: _____ % **b.** Number of full time employees: _____
3. Premium Payor *(Select all that apply):*

   ☐ Proposed Insured(s) ☐ Proposed Owner(s) ☐ Employer/Corporation (Premium included in W-2? ☐ Yes ☐ No) ☐ Other

   If Proposed Owner(s) or Other is selected above, complete questions 3a-3c.

   a. Full legal name *(First, MI, Last, Suffix):* _____

   b. Taxpayer Identification Number *(SSN/ITIN):* _____

   c. Mailing address *(PO Box or Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):*

   If Proposed Insured(s) and Employer/Corporation are selected above, complete questions 3d-3e.

   d. Percentage of split: Employer/Corporation: _____ % Proposed Insured: _____ %

   e. Payor's Social Security or Taxpayer Identification Number *(If other than Owner or Proposed Insured):* _____
4. Billing type *(Select one):* ☐ Pre-Authorized Check *(PAC; **if selected, use applicable PAC form**)* ☐ Individual Direct Bill

   ☐ Group Bill with Invoice/Franchise number ***(Must be provided at the time of business submission):*** _____
5. Frequency *(Select one):* ☐ Monthly *(PAC/Group only)* ☐ Quarterly *(PAC only)* ☐ Semi-annual ☐ Annual
   If annual premiums are paid by installments, an additional charge will apply
6. Is initial premium being submitted with this Application? ☐ Yes ☐ No ***If Yes, use Conditional Receipt.***
7. Policy dating *(Select one):* ☐ Date of Issue *(New Business only)* ☐ Save age *(Premium will be due from Coverage Date)*

   ☐ Monthly Anniversary *(Right to Applies only)* ☐ Specific date *(Up to the 28th of each month):* _____
8. Premium structure *(Radius/Radius Choice only; select one):* ☐ Level ☐ Graded *(Only available on issue ages 18-35)*

K Disability Income Other Coverage Information

1. Does the Proposed Insured currently have disability income insurance in force? ☐ Yes ☐ No

If Yes, complete the following chart. If disability insurance being applied for is replacing this coverage, indicate response by selecting the appropriate box under Being Replaced below and provide effective replacement date.

Company	Type*	Issue Year	Monthly Benefit Amount	Benefit Period	Elimination Period	Employer Pay?	Being Replaced?	Replacement Date
			$			☐ Yes ☐ No	☐ Yes ☐ No	
			$			☐ Yes ☐ No	☐ Yes ☐ No	
			$			☐ Yes ☐ No	☐ Yes ☐ No	

**Type of plan: Individual (I), Group (G) or Association (A)*

2. Is additional contributory group disability income coverage available through the Proposed Insured's employer? ☐ Yes ☐ No

3. Does the Proposed Insured have plans to participate in the future? ***If Yes, provide details in section L*** ☐ Yes ☐ No

4. Is the Proposed Insured eligible for state cash sickness benefits? ☐ Yes ☐ No

5. Will the employer continue the Proposed Insured's salary or income if disabled? ***If Yes, complete questions 5a-5b*** ☐ Yes ☐ No

a. Amount per month: $ _____ **b.** Number of months: _____

6. Is any application for disability, accident or health insurance pending or is the reinstatement of any policy pending for the Proposed Insured? ☐ Yes ☐ No

L Additional Information

Details. *Indicate section letter and question number. If additional space is required, attach another sheet.*

M Disclosures

The Application. This is part of an application for Disability Income and/or Life Insurance. The Application may include a Part 2 and amendments, statements and supplements to either part. The Application will be attached to and made part of the Policy.

Authority of Producers. No producer can change the terms of this Application or any Policy issued by the Company, waive any of the Company's rights or requirements, or extend the time for any payment.

Changes and Corrections. Any material change or correction of the Application will be shown on an amendment of application attached to the Policy. Acceptance of any Policy issued shall be acceptance of any change or correction of the Application made by the Company. Any change in plan of insurance, amount, age at issue, gender, class or benefits shall require the written consent of the Policy Owner and Proposed Insured.

Life only

Charges. If a life insurance policy is issued, insurance coverage will begin as defined in the Life Insurance Coverage Section. Policy charges will begin on the Policy Date, which is defined in the Policy. The Policy Date may occur before insurance under the Policy takes effect. If so, you will be charged premiums during the period in which no insurance was in force. To reduce the likelihood of paying such premiums, the Policy Owner may purchase a TLIR, if eligible, or ask the Company to issue the Policy with a future Policy Date. Requesting a specific Policy Date may cause the Proposed Insured's age for insurance purposes to change and the cost of insurance rates to increase. If you have questions about Policy charges or Policy dating, ask your producer.

Life Insurance Coverage. Insurance coverage under the Policy takes effect when the Policy is delivered and accepted, and the initial premium is paid, provided that on the delivery date (1) the Proposed Insured is alive, (2) all answers on the Application, including any amendments to the Application, are still true and complete, and there have been no changes in the health or insurability of the Proposed Insured from the date the Application was submitted to the Company unless Insurability Protection is provided under a Temporary Life Insurance Receipt (TLIR), and (3) any required statement of insurability is completed. Failure to satisfy all of these requirements will result in no insurance coverage taking effect. If a future date is selected at the time of application, coverage does not begin prior to that date.

General Life Provisions:

- **Owner: This Application assumes that the Insured is Owner unless otherwise designated.** For survivorship policies, the ownership designation assumes Insureds, jointly, or the survivor of them.
- **Beneficiary:** Unless otherwise requested, proceeds shall be paid in one sum. If there is no living or existing beneficiary, the proceeds will be paid to the owner or the owner's estate. For survivorship policies, if both insureds are owners and there is no living or existing beneficiary, the proceeds will be paid to the estate of the last to die of the insureds.

Disability Income only

Coverage. If this Application is for MaxElect, any Coverage issued on this Application will take effect on the Coverage Dates as shown on the Policy Specification provided that the Policy has been issued and delivered and the premium due for the Coverage(s) has been paid, and all answers and statements in this Application are true and complete. If this Application is for a Business Overhead Expense Policy or any other Disability Income issued by the Company, the Policy will take effect if the first premium is paid and the Application is approved by the Company at its Home Office and all statements in this Application are true and complete as if made at the time of delivery. This paragraph shall be subject to the incontestability and time limit of certain defenses provisions of any Policy issued as a result of this Application. For Buy/Sell, the Buy/Sell Agreement is in effect or will be in effect by the first Policy Anniversary. If the Buy/Sell Agreement is not in effect by the first Policy Anniversary, the Policy will be treated as if it were never issued and the Company's only obligation will be to return any premium paid. If a premium is paid to the Producer in exchange for a Temporary Individual Disability Insurance Agreement, the Company is liable only as stated in that Agreement.

N Agreements & Signatures

Acknowledgment of Receipt of the Company Notices and Disclosures. The Proposed Owner (and Proposed Insured, if different) hereby acknowledges that in connection with this Application, the Company's notices about MIB Group, Inc. (formerly known as the Medical Information Bureau), the Company's privacy practices and premium payment information have been provided to and received by the Proposed Owner (and Proposed Insured, if different).

Authorization of Proposed Insured to Obtain and Disclose Information. I authorize the Company to review this Application and the information contained therein and to collect and review such medical and non-medical information as the Company may request. I hereby authorize certain parties that have records or knowledge of me and/or my health to make such information available to the Company and its representatives which includes its reinsurers, its affiliated insurance companies, its agents, employees, and others who perform services for the Company, or as otherwise allowed by law. These parties shall include any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, the MIB, pharmacy data search companies, Department of Motor Vehicles, credit agency, current or former employer, insurance company, and other organizations having information relevant to the issuance or administration of this policy. I further authorize the Company to obtain and conduct a personal history information interview and/or a written inspection in connection with this Application and authorize the Company to obtain an investigative report regarding information about my character, general reputation, personal characteristics and mode of living. I understand that any and all such information obtained by the Company through such interviews, inspections, or reports may be made available to the Company's representatives, which includes its agents, employees, and others who perform services for the Company, or as otherwise allowed by law, for determining eligibility for insurance, reinsurance, reinstatement requests, or changes in benefits. I understand I have a right to receive a copy of any investigative report prepared about me,

to be interviewed in connection with the preparation of the investigative consumer report, and to receive the names and addresses of any consumer reporting agencies to whom requests for information were made. I also authorize the Company, or its reinsurers, to disclose personal health information about me to the MIB in the form of a brief coded report for participation in MIB's fraud prevention and detection programs. Consumers may request copies of their MIB file in writing to: 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. The MIB toll free number is: (866) 692-6901. This authorization shall be valid for 30 months from the date of my signature on this Application. All documents and information submitted to, or acquired by, the Company become property of the Company. A photocopy facsimile or electronic copy of this authorization may be relied upon as if it were an original.

Disability Income MaxElect only – Authorization of Proposed Insured for Payroll Deduction and Benefit Increases. I acknowledge that if payroll deduction is applicable to me, my employer is acting on my behalf when remitting premiums. I authorize MassMutual to contact my employer named in my application periodically to determine if my compensation qualifies me for additional benefits.

Life only – Term Dividend Options. The choices are: Dividend Accumulations/PD (default), Cash, Reduce Premiums – balance to PD.

Variable Life (VL) and Universal Life (UL) Acknowledgments. VL Insurance policy values that are based on the separate account assets are not guaranteed and may increase or decrease in accordance with the experience of the separate account and the death benefit may be variable or fixed based on specified conditions. For VL or UL Insurance, if a single premium is elected as mode or payment, additional premiums may be required to keep the Policy in force. If this Application is for a VL Insurance Policy, a current prospectus for the Policy applied for was received and the Policy meets the investment objectives of the Proposed Policy Owner.

Sales Illustration Certification for products where an illustration is required *(Complete for Life only)*

1. I, the undersigned, acknowledge that a hard copy of a sales illustration matching the Policy as issued must be provided no later than delivery of the Policy. Select one for each applicable policy being applied for confirming how, or if, an illustration was used in the sale of this Policy(ies). If more than 3 policies are being applied for, submit additional Sales Illustration Certification forms for each.

Primary	Add	Alt	
☐	☐	☐	The sales illustration conforms to the Policy as applied for. **If so, it must be signed and submitted with this Application.**
☐	☐	☐	No illustration was used in the sale of this life insurance Policy.
☐	☐	☐	The sales illustration used for the Proposed Insured does not conform to the Policy as applied for.
☐	☐	☐	The sales illustration for the Proposed Insured was shown on a computer screen. The illustration conforms to the Policy as applied for, however, no hard copy was furnished.

Taxpayer Identification *(Complete for Life only)*

If the Proposed Insured will be the Proposed Owner, the Proposed Insured must complete this Taxpayer Identification section. If the Proposed Insured will not be the Proposed Owner, do not complete this section.

2. By my signature, I, the Proposed Insured/Owner, certify under penalties of perjury, that:

- The number shown in Section A (question 5) is my correct Taxpayer Identification Number: ☐ Yes ☐ No
- I am NOT subject to backup withholding: ☐ Yes ☐ No
- I am a U.S. person (including a U.S. resident alien): ☐ Yes ☐ No
- The FATCA exemption code entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. Not Applicable
  Note: While the Company is required by the IRS to include this certification, FATCA does not apply to a U.S. account owned by a U.S. person, so the Company has not included the ability to enter an exemption code. If the Proposed Insured/Owner has indicated that he/she is not a U.S. person, any applicable FATCA information will be captured on the W-8 form.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

N Agreements & Signatures *continued*

Signatures

THE FALSITY OF ANY STATEMENT IN THE APPLICATION FOR ANY POLICY SHALL NOT BAR THE RIGHT TO RECOVERY UNDER THE POLICY UNLESS SUCH FALSE STATEMENT WAS MADE WITH ACTUAL INTENT TO DECEIVE OR UNLESS IT MATERIALLY AFFECTED EITHER THE ACCEPTANCE OF THE RISK OR THE HAZARD ASSUMED BY THE INSURER.

I, the undersigned, have read the Application including all supplements and all statements and answers, and affirm that these statements and answers are true, complete, and correctly recorded to the best of my knowledge and belief.

Signature of Proposed Insured *(If actual age under 18, signature of parent):* _____

Printed name: _____ Date: _____

City/State where application is being signed *(If Proposed Insured is Owner):* _____

Signature of Owner: _____

Printed name: _____ Date: _____

Title *(If applicable):* _____ ☐ Sole Officer

Printed name of Corporation/Partnership/Trust *(If applicable):* _____

City/State where application is being signed: _____

Signature of Producer: _____

Printed name: _____ Date: _____

MassMutual

Client Medical Interview (CMI)

Application Part 2

The Insurer identified below will be referred to herein as the "Company":

Massachusetts Mutual Life Insurance Company

(MassMutual) 1295 State Street, Springfield, Massachusetts 01111-0001

A Personal Information

1. Full legal name *(First, MI, Last, Suffix):* _____
2. Date of birth *(mm/dd/yyyy):* _____
3. Taxpayer Identification Number *(SSN/ITIN):* _____
4. Height and weight information:
   - **a.** Current height *(Feet & inches):* _____
   - **b.** Current weight *(Pounds):* _____
   - **c.** Has your weight changed by more than 10 pounds in the last year? ☐ Yes ☐ No
5. Primary physician/practice:
   - **a.** Full legal name: _____
   - **b.** Business address *(Street, Suite #, City & State or Country, ZIP/Postal Code):*
   - **c.** Phone number: (_____) _____ - _____
   - **d.** Date last seen: _____
   - **e.** Reason last seen: _____
6. Current health insurer: _____
7. Group number: _____
8. Identification (ID) number: _____

B Personal History Information

1. Family history:
   - **a.** Complete all sections of the grid below, to the best of your knowledge, for all immediate family members (i.e. biological parents and/or siblings):

Relative	Health Problems – Include Age of Onset	Age if Living	Age at Death	Cause of Death
Father				
Mother				

To the best of your knowledge, have any of your immediate family members ever been diagnosed by a member of the medical profession with:

- **b.** Cancer, heart disease, diabetes or vascular disease? ☐ Yes ☐ No
- **c.** Polycystic Kidney Disease, Huntington's Disease, Marfan Syndrome, Lynch Syndrome or Cardiomyopathy (heart muscle disease)? ☐ Yes ☐ No

B Personal History Information *continued*

2. Have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

3. Have you used tobacco or nicotine containing products except cigars (e.g. cigarettes, e-cigarettes/vape, pipes, snuff, chewing tobacco or nicotine delivery device such as gum or the patch):

   a. Within the last 12 months? ☐ Yes ☐ No

   b. Within the last 24 months? ☐ Yes ☐ No

4. Have you used cigars within the last 24 months? ☐ Yes ☐ No

   If Yes, provide number of cigars per year: _____

5. Have you used a prescription medication to assist with smoking cessation or as a substitute for smoking (e.g. Chantix, Wellbutrin, etc.) within the last 12 months? ☐ Yes ☐ No

6. To the best of your knowledge, in the last 10 years, have you tested positive or been diagnosed, treated or prescribed medication by a member of the medical profession for any disease or disorder noted below:

   a. A disorder of the heart, arteries or veins including, but not limited to, chest pain, heart attack, high blood pressure, heart murmur, or palpitations? ☐ Yes ☐ No

   b. Any malignant tumor or cancer including, but not limited to, skin cancer, melanoma, colon polyps, leukemia and/or lymphoma? ☐ Yes ☐ No

   c. A disorder of the blood, spleen or immune system including, but not limited to, anemia, blood clots, bleeding, leukemia or lymphoma (excluding Human Immunodeficiency Virus (HIV))? ☐ Yes ☐ No

   d. A disorder of the brain, spinal cord or nervous system including, but not limited to, seizures, tremors, paralysis, dizziness, fainting, headaches, brain tumor, brain aneurysm or bleeding, stroke or TIA (transient ischemic attack)? ☐ Yes ☐ No

   e. An emotional disorder including, but not limited to, depression, anxiety, nervousness, stress, psychosis, suicide thoughts or attempts, anorexia or bulimia, post traumatic stress disorder, obsessive compulsive disorder, bipolar disorder, or attention deficit hyperactivity disorder (ADHD)? ☐ Yes ☐ No

   f. A disorder of the eyes, ears, nose, throat or sinuses including, but not limited to, any partial or complete loss of hearing, vision or speech? ☐ Yes ☐ No

   g. A disorder of the respiratory system including, but not limited to, asthma, allergies, shortness of breath, sarcoidosis, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), pneumonia, sleep apnea, or tuberculosis? ☐ Yes ☐ No

   h. A disorder of the digestive system, liver, pancreas or gall bladder including, but not limited to, hepatitis, jaundice, ulcers, intestinal bleeding or polyps, colitis, Crohn's disease (ileitis), recurrent indigestion, diarrhea, diverticulitis or weightloss surgery? ☐ Yes ☐ No

   i. A disorder or impairment of the muscles, bones, joints, nerves, spine, neck or back including, but not limited to, arthritis, gout, sciatica or amputations? ☐ Yes ☐ No

   j. A rheumatologic disorder including, but not limited to, Epstein-Barr virus, Lyme disease, chronic fatigue syndrome, fibromyalgia, or lupus? ☐ Yes ☐ No

   k. A disorder or disease of the thyroid or endocrine system including, but not limited to, diabetes, hypothyroidism, hyperthyroidism, Grave's Disease, pituitary dysfunction, high cholesterol? ☐ Yes ☐ No

   l. A disorder or impairment of the kidneys or urinary tract including, but not limited to, chronic kidney disease, enlarged prostate, glomerulonephritis, or findings of high protein or high sugar in the urine? ☐ Yes ☐ No

   m. A disorder of the skin including, but not limited to, eczema or psoriasis? ☐ Yes ☐ No

   n. A disorder or disease of the uterus, cervix, ovaries or breasts including, but not limited to, fibrocystic breast disease, uterine fibroids, endometriosis? ☐ Yes ☐ No

   o. Multiple miscarriages, complicated pregnancy or infertility evaluation? ☐ Yes ☐ No

7. Are you currently pregnant? ☐ Yes ☐ No

8. In the last 10 years, have you:

   a. Used cocaine, barbiturates, amphetamines, heroin, narcotics, stimulants, hallucinogens or other controlled substances not prescribed by a physician? ☐ Yes ☐ No

   b. To the best of your knowledge, tested positive for or been diagnosed, treated or prescribed medication by a member of the medical profession for alcoholism or drug abuse? ☐ Yes ☐ No

B Personal History Information *continued*

9. In the last 5 years, have you:

a. Had an application for life, disability, long term care or health insurance declined, postponed, rated or restricted? ***If Yes, provide date & reason given for adverse underwriting decision in section C – Additional Information.*** ☐ Yes ☐ No

b. Had a sickness or injury for which a disability claim was made or payments, benefits or pension benefits were received? ☐ Yes ☐ No

10. In the last 3 years, unless previously stated on this Application, have you:

a. Had a physical exam, check-up or evaluation by a medical professional for any known symptom or condition except those previously disclosed? ☐ Yes ☐ No

b. Scheduled for medical treatment or surgery, an electrocardiogram, x-ray, blood test or other diagnostic test, excluding an HIV test, that you have not completed? ☐ Yes ☐ No

c. Had a medical professional perform surgery or place you overnight in a hospital, clinic or other medical or mental health facility for a condition not previously stated on this Application? ☐ Yes ☐ No

11. Are you currently under medical treatment or taking any prescription medications (other than contraceptives) for anything not previously stated on this Application? ☐ Yes ☐ No

12. Are you currently taking any herbal or non-prescription medication at least weekly? ☐ Yes ☐ No

C Additional Information

Details. *Indicate section letter and question number.*

D Agreements & Signatures

THE FALSITY OF ANY STATEMENT IN THE APPLICATION FOR ANY POLICY SHALL NOT BAR THE RIGHT TO RECOVERY UNDER THE POLICY UNLESS SUCH FALSE STATEMENT WAS MADE WITH ACTUAL INTENT TO DECEIVE OR UNLESS IT MATERIALLY AFFECTED EITHER THE ACCEPTANCE OF THE RISK OR THE HAZARD ASSUMED BY THE INSURER.

I, the undersigned, have read this Application Part 2 (Client Medical Interview) including all supplements and all statements and answers ("Application"), and affirm that these statements and answers are true, complete, and correctly recorded to the best of my knowledge and belief. The Application will be attached to and made part of the Policy.

Signature of Proposed Insured: _____

Printed name: _____ Date: _____

City/State where Application is being signed: _____

Signature of Witness: _____

Printed name: _____ Date: _____

MassMutual

Notice and Consent Form for AIDS Virus (HIV) Antibody/Antigen Testing (California)

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid, and/or urine for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody/antigen test that is performed is actually a series of tests done by a medically accepted procedure. These tests are extremely reliable, but in rare instances may be positive when the person is not infected with the virus (a false positive). The test may also result in a false negative, especially when the infection occurred within the previous 3-6 months.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions and you may wish to consider further independent testing. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. A negative test does not mean that you have not been infected with the AIDS virus, due to the 3-6 month incubation period, or that you cannot get the virus in the future.

You may wish to consider counseling prior to taking this test, at your own expense, to learn more about AIDS and how to protect yourself from HIV infection. You may wish to contact your personal physician if you have any questions. A list of counseling facilities is provided for your information.

You will not be notified if your test results are negative. If they are positive, your application for insurance will be declined. You are entitled to the results. A trained person (your personal physician, for example) should convey the results so that they can be clearly explained to you. Please list the name and address of your personal physician to whom you would like positive results sent.

(Name) _____ (Address) _____

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons, in connection with insurance you have or are applying for with the Insurer, the Insurer may disclose test results to its affiliates, reinsurers or employees who have responsibility for making decisions regarding your application or policy, or outside counsel. Test results may be reported to a medical information exchange using strict confidentiality procedures including the use of general codes that are also used to report other diseases or conditions not related to AIDS. Other insurers may require an HIV related test in the future should they learn of a previous abnormal test. There will be no other disclosure of test results except as may be required or permitted by law or as authorized by you.

I have read and understood this Notice of HIV Antibody Testing Consent Form and have been given written material about AIDS and counseling information. I voluntarily consent to the collection of blood, oral fluid and/or urine from me, the testing of that blood, oral fluid and/or urine, and the disclosure of the results as described above. I understand that I have the right to request and receive a copy of this consent form.

No attempt to modify or amend this form will change its terms or in any way be binding upon the Insurer or any of its agents or contractors. A photocopy of this form will be valid as the original.

Signature of Proposed Insured **X**_____ Date _____

Or Parent/Guardian

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

MassMutual

HIV Infection Information for California Insurance Applicants

AIDS (acquired immune deficiency syndrome) and related conditions are caused by the human immunodeficiency virus (HIV). Certain cells of the body which are necessary to fight disease are invaded by this virus. This leaves the individual vulnerable to infections and malignancies (cancers). Symptoms of infection with HIV may not become apparent for several years after exposure. The symptoms are variable but most often will include swollen glands, weight loss and fever. In addition, many will have persistent diarrhea or develop other infections. One of the most common infections to occur in those who have been previously infected with HIV is an otherwise unusual lung disease (pneumocystis carinii pneumonia). It is with the development of this that the diagnosis of AIDS is most often made. An otherwise unusual skin cancer (Kaposi's sarcoma) is also frequently seen in HIV infected persons.

The HIV is spread primarily by sexual (especially male homosexual) contact, needle sharing or from a pregnant woman to her unborn child. Risk of infection is increased by having sex with multiple partners or by sharing needles with drug abusers. Early in the epidemic, it was spread through contaminated blood and blood products but since testing became available in 1985, this source of infection has been all but eliminated in the U.S.

A blood, oral fluid and/or urine test is used to detect the presence of HIV infection. This is actually a series of tests which are extremely accurate. These tests do not make the diagnosis of AIDS but identify those who are infected with HIV. An infected person has a significant chance of developing AIDS.

If your test for HIV infection is positive, you can infect others. Therefore, you should consult with your personal physician for follow-up care and counseling. You should not donate blood, sperm or body organs. Do not share drugs with others and avoid exchanging body fluids during sexual activity (A condom should be used). It is best to completely avoid intimate sexual contact. You should not share toothbrushes, razors, tweezers or anything that could be contaminated with blood. If you are a woman, you should consider postponing pregnancy. You may continue with usual social and work activity. The infection is not spread by sharing toilet facilities, eating utensils or workspace. Shaking hands, hugging or kissing on the cheek are safe practices.

A negative test indicates that you are not infected. However, if an infection is recently acquired, there may be no test evidence of this for several months. In very rare instances, the test remains permanently negative in infected persons. A negative test does not mean that you are immune to infection. No one is immune. It only serves to indicate that very sensitive tests have not detected any evidence of infection.

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N201CA 1004

LIST OF CALIFORNIA COUNSELING RESOURCES

Everyone is urged to become better informed about AIDS, HIV infection, the HIV test and its results. Your personal physician may be the best source of information.

There are other counseling resources in California. This list, which contains some of these resources, has been obtained from public record and is subject to change. Massachusetts Mutual and its Affiliated Companies cannot recommend or guarantee the quality or nature of the service provided by these resources.

California AIDS Hotline:	1-800-367-AIDS (toll-free in California) 1-415-863-AIDS (San Francisco area) 1-888-225-AIDS (toll-free TTY for the hearing impaired)
CDC National AIDS Hotline:	1-800-342-AIDS 1-800-344-7432 (Spanish) 1-800-243-7889 (Deaf/hard of hearing -TTY)

MassMutual

Owner Designation of Secondary Addressee

For use in California

Use this form to designate a secondary address to receive notices of past due premium and termination of your insurance policy. If your premium is overdue, we will send notice of the past due premium and/or termination of your policy to both you and the secondary addressee. If you would like to designate a secondary addressee, please complete the sections below. You may change your secondary addressee at any time by submitting written notice to our home office.

A Policy Information

1. Policy number(s): _____
2. Insured full legal name *(First, MI, Last, Suffix):* _____
3. Owner full legal name *(First, MI, Last, Suffix):* _____
4. Phone number: (____) ____ - ____ Extension: ____ ☐ Home ☐ Work ☐ Mobile
5. Owner email address: _____

B Secondary Addressee Information

1. Secondary addressee full legal name *(First, MI, Last, Suffix):* _____
2. Mailing address *(PO Box or Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):*

   _____

   _____
3. Phone number: (____) ____ - ____ Extension: ____ ☐ Home ☐ Work ☐ Mobile

C Agreements & Signatures

Signature of Owner: _____

Printed name: _____ Date: _____

Title *(If applicable):* _____ ☐ Sole Officer

Printed name of Corporation/Partnership/Trust *(If applicable):* _____

Signature of Additional Policy Owner *(If applicable):* _____

Printed name: _____ Date: _____

Title *(If applicable):* _____

Printed name of Corporation/Partnership/Trust *(If applicable):* _____

D Submission Instructions

For more information or general questions, use the resources below or for additional information regarding your policy, visit www.massmutual.com. Once you have reviewed and completed the form, return this page for processing. We will only accept responsibility for forms that are submitted as indicated below.

Phone: 1-800-272-2216 Monday through Friday, 8 a.m. – 8 p.m. Eastern Time	**Mail:** MassMutual Document Management Hub 1295 State Street Springfield, MA 01111-0001	**Life Fax:** Attention: Life Hub 1-866-329-4527 **DI Fax**: Attention: DI Hub 1-860-562-6130 *Retain this original and the fax machine confirmation statement for your files.*

MassMutual

Producer's Statement

Use this form for all Life New Business applications. This form must completed and signed by the Soliciting Producer.

A Policy Information

1. Risk classification presented to:

a. Insured 1: _____

b. Insured 2 *(If applicable):* _____

2. Do you want an offer if the case is approved other than as applied for? ☐ Yes ☐ No

3. Is this part of a multi-policy case (i.e. family members, business partners, etc.)? ☐ Yes ☐ No

If Yes, provide associated policy number(s): _____

4. Are there any other applications (e.g. Disability, Long Term Care) being submitted concurrently with this Application or within the last two months? ☐ Yes ☐ No

If Yes, provide associated policy number(s): _____

5. Is the policy being applied for a replacement? ***If Yes, complete applicable replacement forms.*** ☐ Yes ☐ No

6. Will dividends from an existing MassMutual policy be used to pay all or part of the initial premium on this policy? ***If Yes, complete Service Request Form (F5341).*** ☐ Yes ☐ No

7. Is the Life Insurance being applied for in conjunction with the purchase of a Single Premium Immediate Annuity? ☐ Yes ☐ No

If Yes, provide associated policy number(s): _____

8. Are you aware of whether the Proposed Owner or Proposed Insured has arranged, or discussed arranging, any financing for the purchase of this policy? ***If Yes, complete applicable Premium Financing Supplement (F7002).*** ☐ Yes ☐ No

9. Do you have any knowledge or reason to believe the Proposed Insured has any present or future intention to sell or assign this policy, or has ever sold or assigned any policy, to a life settlement, viatical or other secondary market provider? ☐ Yes ☐ No

10. Did every person signing this Application understand and answer each question in English? ***If No, complete applicable Acknowledgment Regarding English Language Materials and Translation (FR1119).*** ☐ Yes ☐ No

If No, indicate language: _____

11. For purposes of completing the Telephone Inspection (PHI), does the Proposed Insured:

a. Have a hearing impairment? ☐ Yes ☐ No

b. Have a preferred language other than English? ***If Yes, complete applicable Acknowledgment Regarding English Language Materials and Translation (FR1119).*** ☐ Yes ☐ No

If Yes, indicate language: _____

12. Market type *(Select all that apply):*

☐ N/A
☐ Business Owner
☐ Existing Customer
☐ Family Markets
☐ Lesbian, Gay, Bisexual & Transgender (LGBT) Markets
☐ Multicultural Markets
☐ SpecialCare – Families with special needs*
☐ Women's Markets
☐ Other *(Specify):* _____

**Note: The receipt of insurance benefits by a beneficiary or dependent with special needs could negatively affect that individual's eligibility for government benefits.*

Complete question 13 for Variable products only, otherwise skip to section B – Producer Compensation Information.

13. Did you deliver a current copy of the Prospectus and any applicable supplements? ☐ Yes ☐ No

If Yes, provide Prospectus Effective Date *(from front cover of Prospectus; mm/dd/yyyy):* _____

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

B Producer Compensation Information

Complete the first line for all applications and provide additional compensation arrangements if applicable.

	Producer Type	Producer ID #	Printed Name	Agency #/ Distributor ID	Entity Name/Entity #	% 1st Year Commission	% Renewal Commission
1	**Soliciting**						
2							
3							
4							
5							
6							
7							
8							

Agency Split *(For Survivorship Whole Life 2008 Series only):* If the sale of this policy will be credited to more than one agency/entity, list % for each	**Agency #**	**% of Split**	**Total: 100%**	**Total: 100%**

C Contact Information

Agency Contact *(To be used when the Underwriter/Case Manager has questions or needs additional information about this case)*

1. Contact name: _____

2. Phone number: (_____) _____ - _____ Extension: _____ ☐ Home ☐ Work ☐ Mobile

3. Email address: _____

Additional Agency Contact *(If applicable)*

4. Contact name: _____

5. Phone number: (_____) _____ - _____ Extension: _____ ☐ Home ☐ Work ☐ Mobile

6. Email address: _____

D Agreements & Signatures

I certify to the best of my knowledge, information and belief that:

- The statements made in this Producer's Statement are true and accurate.
- Each question in the Application was asked of the Proposed Insured(s) and Proposed Owner(s) and accurately recorded.
- All required forms and notices were provided to the Proposed Owner (and Proposed Insured, if different) prior to completing the Application.
- I am unaware of any suspicious or unusual activities, including but not limited to Anti-Money Laundering (AML) "red flags" as described in my AML training or other materials, arising out of or in connection with, the sale of this policy. I have reported suspicious activity, if any, to the appropriate individuals in accordance with MassMutual's AML program.
- The policy applied for is consistent with the financial needs of the Proposed Insured(s) and/or Owner(s).
- I am unaware of any information that would adversely affect any of the Proposed Insured's eligibility, acceptability or insurability.
- If this is an Application for Life Insurance with Long Term Care Access Rider, all of my applicable state life and health licenses were in place, and I completed all applicable MassMutual and state long-term care pre-sale and ongoing training requirements prior to solicitation.

Signature of Soliciting Producer: _____

Printed name: _____ Date: _____

Producer ID #: _____

Email address: _____

MassMutual

Coverage & Premium Payment Information

Disclosures

Insurance Coverage Taking Effect

Thank you for applying for a MassMutual life insurance policy. This disclosure is intended to provide you important information about how policy charges accrue in relation to the date insurance coverage takes effect under the terms of your policy. Please read the disclosure and discuss it with your MassMutual representative.

What is my Policy Date?

It is important to understand some important dates. These dates may be defined further in your policy.

- Policy Date. The Policy Date is the date on which policy charges (premiums) begin to accrue. Clients may choose a specific Policy Date. Otherwise, the Policy Date will be set to the Issue Date.
- Issue Date. The Issue Date is the date the Company issues the policy.
- Delivery Date. The Delivery Date is the date the policy is delivered to you for acceptance.

When does Insurance Coverage Begin?

The date insurance coverage under the policy begins varies from policy to policy according to the specific policy issued and any insurability changes during the underwriting process. Generally, except as otherwise provided in the terms of any temporary insurance agreement, or the Part 1 Application for Life Insurance, insurance coverage under the policy takes effect when the policy is delivered and the initial premium is paid, provided that on that date the insured(s) is alive, all answers on the application, including any amendments to the application presented to you on the Delivery Date, are still true and complete and there have been no changes in the insured(s) health or insurability. If a future Policy Date is selected at the time of application, coverage does not begin prior to that date.

How does the date Insurance Coverage Begins compare to the Date Policy Charges Begin?

The Policy Date, the date the charges begin, may occur before insurance under the policy takes effect, such as when coverage takes effect on the Delivery Date. If your Policy Date occurs before insurance takes effect, you will be charged for premiums for a period during which no insurance was in force. To reduce the likelihood of paying such premiums, the Policy Owner may purchase a Temporary Life Insurance Receipt, if eligible, or ask the Company to issue the policy with a future Policy Date.

How does Future Dating or Redating Affect my Policy?

You may specify a policy date or ask the Company to reissue your policy with a new Policy Date matching the date insurance coverage begins. Requesting a new Policy Date may cause your age for insurance purposes to change and the cost of insurance rates to increase. Further, the Policy Date is used to determine the date on which the suicide, contestability and surrender charge periods begin to run. There will be no coverage under the policy before the new Policy Date.

Please review your policy and consult your MassMutual representative if you have questions about policy charges or policy dating.

Disclosure Statement About Our Policy's Premium Payment Options

Please read this information carefully. As a policyholder of MassMutual, you have the right to choose among four payment plan options for paying your annual premium. Each payment option, other than annual, costs more money. Among our policyholders, the additional cost varies depending upon the type of policy and its original issue date.

A generic description of the payment options and range of costs, expressed as dollars and as annual percentage rates, are described below.

Premium Payment Options. You may pay premiums once a year (annually), twice a year (semi-annually), or four times a year (quarterly) or twelve times a year (monthly). If you pay your annual premium by installments, there will be an additional charge:

- If you pay semi-annually, the additional charge equals an annual percentage rate (APR) in the range of 8.2% to 18%. This would amount to an additional annual charge in the range of $20 to $43 on an annual premium of $1,000.
- If you pay quarterly, the additional charge equals an annual percentage rate (APR) in the range of 2.4% to 23.7%. This would amount to an additional annual charge in the range of $9 to $88 on an annual premium of $1,000.
- If you pay monthly, the additional charge equals an annual percentage rate (APR) in the range of 4.3% to 22.1%. This would amount to an additional annual charge in the range of $20 to $103 on an annual premium of $1,000.

There may be other premium payment options available on certain products. Contact MassMutual at 1-800-272-2216 for more information.

If you would like to know the exact dollar amount of the additional charge or the Annual Percentage Rate that you are paying because you pay your annual premium in installments, you may access our "Modal Charge Disclosure and Annual Percentage Calculator" link at www.massmutual.com/calculators and follow the simple instructions. Alternatively, you may call this toll free number 1-800-272-2216 and we will provide you with the information.

How To Change Your Premium Payment Option*. You also have the right to change this option during the lifetime of your policy. In order to make a change, you must either:

- Inform your MassMutual agent that you wish to change the premium payment frequency for your policy; or
- Notify MassMutual in writing via regular mail (MassMutual Customer Service Hub at 1295 State Street, Springfield, MA 01111- 0001) or contact us at www.massmutual.com that you wish to change the premium payment frequency for your policy's premium. To request a change in your policy's premium payment frequency, be sure to include the policy number in your correspondence; or
- Contact a MassMutual Customer Service Representative at 1-800-272-2216 and inform the representative that you wish to change the premium payment frequency for your policy.

This notice does not change any of the terms of your MassMutual policy.

*If your premium is paid through a payroll deduction, there may be limitations on your ability to change the payment option. Contact your MassMutual agent to determine if your premium payment option can be changed.

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

MassMutual

NOTICE OF INFORMATION PRACTICES

Collection of Information

In order to underwrite and administer your insurance coverage, we, the Massachusetts Mutual Life Insurance Company, or its Affiliated MML Insurance Company to whom you are applying to for insurance, must collect a certain amount of necessary and helpful information. The amount and type of information collected may vary depending upon the amount and type of coverage applied for. In general, we will be seeking information about your age, occupation, finances, physical condition, health history, mode of living, avocations, and other personal characteristics. In addition, your agent may aid in the collection of this information and collect information to update and improve your insurance program.

Sources of Information

You are our most important source of information. We may also collect or verify information by contacting medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employer and business associates, family, friends and neighbors, and other insurance companies to which you have applied. We may collect information by exchanges of correspondence, by telephone, and by personal contact. In some cases we may ask an insurance support organization to collect information and submit an investigative consumer report to us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

Disclosure of Information

Any information obtained will be treated confidentially. Under some circumstances we, or your agent, may make disclosures of personal information, without your authorization, to third parties. Some of the persons or organizations to whom certain items of information may be disclosed are as follows:

- Persons or organizations which perform business, professional, or insurance functions for us;
- Your agent, General Agent, consumer reporting agencies hired to prepare investigative reports, and other insurance companies to which you have applied for coverage or benefits;
- Your attending physician or treating medical professional.

A description of the circumstances under which information about you might be disclosed without your authorization to the types of persons and organizations referred to above will be sent to you upon request.

Access to and Correction of Information

You have a right to learn the nature and substance of any personal information about you in our files upon written request. Should you feel any information we have in our files is inaccurate, incomplete or irrelevant, you may request correction, amendment, or deletion of that information. A description of access and correction procedures will be sent to you upon your request.

Should you have any questions about the above or about our information practices please contact the Underwriting Department.

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

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MassMutual

Important Privacy & Consumer Information

At Massachusetts Mutual Life Insurance Company ("MassMutual"), we recognize that our relationships with you are based on integrity and trust. As part of that trust relationship, we want you to understand that in order to provide our products and services to you, we must collect, use and share personal information about you. This Privacy Notice describes policies and practices about how we protect, collect and share personal information related to the products and services you receive from us, including life insurance, disability income insurance, long-term care insurance, and individual annuities. It also describes how you can limit some of that sharing.

Disclosures

Privacy Notice

We protect your personal information by:

- Using security measures that include physical, electronic and procedural safeguards to protect your personal information from unauthorized access or use in accordance with state and federal requirements.
- Training employees to safeguard personal information and restricting access to personal information to those employees who need it to perform their job functions.
- Contractually requiring business partners with whom we share your personal information to safeguard it and use it exclusively for the purpose for which it was shared.

Personal information we may collect. The types of personal information we may collect depend on the type of product or service you have with us and may include:

- Information that you provide to us on applications or forms, during conversations with us or our representatives, or when you visit our website (for example, your name, address, Social Security number, date of birth, income, and assets, beneficiaries, and medical or health information).
- Information about your transactions with us and our affiliates, including your policy coverages, premiums, and payment history.
- Information from third parties such as consumer or other reporting agencies and medical or health care providers.

We may share all of the personal information we collect, as described above, with:

- Agents, brokers and others who provide our products and services to you;
- Our affiliated companies, such as insurance or investment companies, insurance agencies or broker-dealers that market our products and services to you;
- Companies that perform marketing or administrative services for us;
- Nonaffiliated companies in order to perform standard business functions on our behalf including those related to processing transactions you request or authorize, or maintaining your policy or contract;
- Courts and government agencies in response to court orders or legal investigations;
- Credit bureaus; and
- Other financial institutions with whom we may jointly market products, if permitted in your state.

In addition, we may share certain of your personal information with your MassMutual financial professional, if he or she is a career agent of ours who terminates their relationship with us to join another financial institution (whom we call a "departing MassMutual financial professional") so that he or she can continue to work with you at his or her new company.

Please note that any personal information consisting of medical or health information is only shared with third parties to perform business, professional or insurance functions on our behalf or as authorized by you.

Important privacy choices. MassMutual respects your privacy choices. If you have a relationship with a departing MassMutual financial professional, as described above, and you prefer that we do not share your personal information, such as information about your insurance policies or contracts held with us, with him or her under these circumstances, you can opt out of this sharing by directing us not to do so. If you wish to opt out of the sharing of your personal information with your departing MassMutual financial professional, you may:

- Call us at (800) 272-2216.

You may make this privacy choice and contact us at any time, however, if we do not hear from you we may share your information with your departing MassMutual financial professional as described above. If this is a joint account, if one joint owner tells us not to share information that choice will apply to the other owner or owners. If you have already told us your choice, there is no need to do so again.

If you have not purchased a product or service through a MassMutual financial professional or you do not have a relationship with a MassMutual financial professional, as described above, you do not need to contact us as we will not share your personal information other than as described in this notice.

Other than as described above, we will only share your personal information as permitted by law and, if the law requires us to obtain your consent or give you the opportunity to opt out of some types of sharing, we will do so before sharing the information.

Certain state laws may provide residents with additional protections for personal information. If you are a resident of one of the following states, we will not share your personal information with your departing MassMutual financial professional unless we receive your express consent:

Arizona	Massachusetts	North Carolina
California	Minnesota	North Dakota
Connecticut	Montana	Ohio
Georgia	Nevada	Oregon
Illinois	New Jersey	Vermont
Maine	New Mexico	Virginia

If you are no longer our customer, we may continue to share your personal information as described in this Privacy Notice.

If you have any questions or concerns about this Privacy Notice, please contact us at (800) 272-2216.

Consumer Notification

This notice is to inform you that a consumer report or an investigative consumer report may be obtained from a consumer reporting agency for the purpose of evaluating your insurance application. The report may contain information bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living, which has been obtained from public record sources or through interviews with you, your family, neighbors, friends or associates. You have a right to receive a copy of the investigative consumer report from the consumer reporting agency that conducts the investigation.

Medical Information Bureau Notice

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the MIB Inc., formerly 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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 if you question the accuracy of information in MIB's file. You may contact MIB and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

The purpose of the bureau is to protect its member companies and their policyholders from the costs created by people who try to hide facts about their insurability. Information furnished by the bureau cannot be used as a basis for evaluating risks. However, it may be used to alert us to the possible need for further investigation. THE BUREAU DOES NOT HAVE MEDICAL REPORTS FROM HOSPITALS AND DOCTORS. THE INFORMATION IN ITS FILES DOES NOT SHOW WHETHER AN INSURANCE APPLICATION WAS ACCEPTED, PLACED IN AN INCREASED PREMIUM CLASS OR DECLINED. **(This notice is only valid where permitted by law.)**

Our Purpose

Part of our basic Company purpose is to provide insurance at the lowest possible cost. The underwriting process is necessary both to assure this low cost and to make sure that each policyholder contributes his or her fair share of the cost. The procedures described above benefit you as a policyholder, because they assist us in providing your insurance at the lowest possible cost.

This Privacy Notice is being provided on behalf of the following insurance companies: Massachusetts Mutual Life Insurance Company (MassMutual), C.M. Life Insurance Company and MML Bay State Life Insurance Company.

MassMutual

Temporary Life Insurance Receipt

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY
(MassMutual) 1295 State Street, Springfield, Massachusetts 01111-0001

Person(s) Proposed for Life Insurance

Printed Name of Proposed Insured 1:

First Name | Middle Initial | Last Name | Suffix

Printed Name of Proposed Insured 2 *(if applicable):*

First Name | Middle Initial | Last Name | Suffix

This Temporary Life Insurance Receipt ("TLIR") is subject to the Terms and Conditions on the following page. Submission of this TLIR may provide limited temporary life insurance coverage for a limited period of time if the answer to each of the following health questions is "No". If any question is answered "Yes" or left blank, there is no life insurance coverage under the TLIR and no payment may be collected.

Health Questions

	Proposed Insured 1	Proposed Insured 2
1. Has any Proposed Insured:		
a. Within the past two (2) years, been treated for or had treatment recommended by a health professional for Cancer, Heart Attack, Heart Disease, Chest Pain, Stroke, Alcohol or Drug Use, or Immune System Disorder (not including HIV tests)?	☐ Yes ☐ No	☐ Yes ☐ No
b. Within the past 90 days, other than for a normal pregnancy or childbirth, been admitted to a hospital or medical facility, been advised to be admitted, or had surgery performed or recommended by a health professional?	☐ Yes ☐ No	☐ Yes ☐ No
2. Does any Proposed Insured have medical tests or examinations scheduled in the next 90 days except for pregnancy or childbirth?	☐ Yes ☐ No	☐ Yes ☐ No

Agreements and Signatures

On _____ an amount of $ _____ was received or authorized as payment.
Date

The individuals signing below agree that they have paid or authorized as payment the amount indicated above and have received and read (or had read to them) the TLIR in its entirety. They understand and agree to its Terms and Conditions as stated on Page 2 of this TLIR. To the best of their knowledge and belief, the answers to all Health Questions stated above are complete, true, and were correctly recorded before they signed their names below.

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.

▶ Signed at: _____
City and State where Owner Signed

X _____ _____
Signature of Proposed Insured 1 | Date

X _____ _____
Signature of Proposed Insured 2 | Date

X _____ _____
Signature of Proposed Owner | Date

X _____ _____
Signature of Producer | Date

MassMutual

Temporary Life Insurance Receipt

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY
(MassMutual) 1295 State Street, Springfield, Massachusetts 01111-0001

An amount of $ _____ was received or authorized as payment for limited temporary life insurance on the life/lives of:

Printed Name of Proposed Insured 1:

First Name	Middle Initial	Last Name	Suffix

Printed Name of Proposed Insured 2 *(if applicable):*

First Name	Middle Initial	Last Name	Suffix

Received by:

X _____ on _____
Signature of Producer Date

Terms and Conditions

Summary. This Temporary Life Insurance Receipt (TLIR) provides a limited amount of temporary life insurance in accordance with the policy identified in the application for a limited period of time on the individual(s) proposed for insurance, subject to the terms and conditions of this TLIR. It does not guarantee that a life insurance policy will be issued and does not provide disability, long term care or waiver of premium benefits. This agreement is not applicable and no temporary insurance is available under this TLIR if it is issued in association with an application for a conversion or a guaranteed insurability option. No agent or individual is authorized to waive or alter the terms of this TLIR. As used herein, "the Company" refers to the Massachusetts Mutual Life Insurance Company, and "Application" refers to the application for the life insurance policy ("Policy") associated with this TLIR.

Payment and Return of Payment. Make all checks or other payments payable to MassMutual. Do not make any checks or other payments payable to the producer or leave the payee section blank. The minimum payment required to pay for insurance coverage under the TLIR is the amount equal to a one-month premium under the policy applied for, regardless of the face amount applied for and the mode or frequency of payment selected for the proposed policy ("Minimum Payment").

Any premium amount greater than or equal to the Minimum Payment required may be collected to bind this TLIR. If a death benefit is due under the TLIR, the initial payment received will be retained by the Company in exchange for the limited insurance provided; however, if the payment received was greater than the Minimum Payment required, the Company will return the excess amount to the owner. If no death occurs while this temporary insurance is in force and a Policy is issued, the payment received will be applied towards the first Policy premium. If no death occurs and no Policy is issued, or the temporary insurance is terminated, the payment received will be returned to the owner.

Insurability Protection. Subject to the restrictions contained in this paragraph, any health changes that occur after the latest of (1) the date the Application Part 1 and Part 2 have been completed and signed, or (2) the date this TLIR has been completed and signed and the Minimum Payment required with it has been received, or (3) the date that any required medical examination(s) and tests are completed will not be considered in determining whether to issue the Policy for which the Proposed Insured has applied. The Company reserves the right to limit coverage under the Policy, based upon its assessment of any such changes in health, to the lesser of (1) the amount applied for, or (2) $1,000,000. Insurability Protection does not apply to any additional benefits or riders that provide coverage other than life insurance. No Insurability Protection coverage is provided if (1) the answer to any of the Health Questions is "Yes" or left blank, or (2) health changes are caused by self-inflicted injury.

Eligibility. Proposed Insured(s) are eligible for this TLIR and Insurability Protection if they are older than 15 days old and younger than 75 years old as of the date of this TLIR, and if the answer to all Health Questions is "No". If any question is answered "Yes" or left blank, there is no life insurance in force under this TLIR, no Insurability Protection is provided and no payment may be collected. If this TLIR is issued in

conjunction with an Application for insurance on two individuals, and one individual answers "Yes" to any Health Questions, there is no life insurance in force under this TLIR for either individual and no Insurability Protection is provided for either individual, and no payment may be collected.

Start Date for Coverage. Insurance under this TLIR begins on the date of this TLIR if, and only if, the Minimum Payment has been collected and the Part 1 of the Application has been completed and signed on the same date or prior to the date of this TLIR. **However there is no life insurance coverage in force under this TLIR if the instrument submitted as payment is not honored or there are insufficient funds to pay the required Minimum Payment as set forth in the Payment and Return of Payment section, above.** Payments by wire transfer or payroll deduction are deemed collected when the required amount is received by the Company.

Stop Date for Coverage. Insurance and Insurability Protection under this TLIR will end on the earliest of:

(1) 90 days following the start date;

(2) 30 days following the start date if the Company has not received Part 2 of the Application and all initial underwriting requirements (internally published age & amount requirements);

(3) The date the Company refunds the payment made or mails a notice indicating the temporary insurance is terminated (the Company may terminate this temporary insurance at any time);

(4) The date the Application is withdrawn or refund of the payment collected is requested;

(5) The date the owner or applicant refuses to accept the life insurance Policy issued; or

(6) The effective date of the new life insurance Policy as described in the Part 1 Application.

Changes in the Amount Applied for After Issue. If pursuant to Provision 5 in the Stop Date for Coverage Section, coverage would end because the owner or applicant refused to accept the life insurance Policy issued and the owner or applicant has requested a change from the Policy originally applied for ("Change") to a different policy or combination of policies, this TLIR will continue for an additional 30 days from the date the owner or applicant refuses to accept the life insurance Policy issued and requests the Change, provided any additional amount necessary to meet the Minimum Payment has been collected.

Benefits. Upon receipt of due proof that the insured(s) died while this TLIR was in force, the Company will pay the benefit due under this TLIR to the beneficiary or beneficiaries named in the Application.

If more than one beneficiary is named under this TLIR and/or there are other TLIRs in force on the same insured(s), each beneficiary will receive a share of the TLIR benefit, subject to the maximum defined in the following paragraph, equal to his or her proportionate interest in the death benefit(s) that would have been payable had the policy or policies applied for been in force.

The maximum aggregate benefit payable under all TLIRs on the same insured(s), including this TLIR, is the lesser of (1) $1,000,000, or (2) the total amount of life insurance currently applied for, including the death benefit applied for under any riders, and excluding any disability coverage. Regardless of the number of TLIRs in force for an Insured(s), the Company's coverage will be limited to the maximum aggregate benefit. The Company will pay only one benefit under a single TLIR regardless of the number of insureds named and deaths that occur. If two insureds are named on a single TLIR, a benefit is payable only upon the second death occurring during TLIR coverage.

At no time will individual(s) be eligible to receive benefits under both a TLIR and the life insurance policy issued in association with that TLIR.

Contestability and Suicide. The Company may contest the validity of the insurance coverage or Insurability Protection pursuant to this TLIR, and deny any benefit due, for any material misrepresentation of fact made on this TLIR or the Application, which includes the Part 1, the Part 2 and any amendments and supplements to either part. If a Proposed Insured commits suicide while the temporary insurance is in effect, no death benefit will be paid; the Company's only liability will be to return the initial payment received to the Owner named in the Application.