NOTICE TO PRODUCER

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

Please complete the application properly and ensure that you have satisfied all of our requirements. Please follow these instructions carefully. All forms must be completed in full and must be legible. We sincerely appreciate your business.

DO

- Give the Notice to Proposed Insured and/or Owner before completing the application.
- Print in black ink.
- Obtain all necessary signatures.
- Ask all questions and fully and accurately record all answers given – the application will be a part of any policy issued.
- Promptly schedule any required exams.
- Obtain proper identification and sufficient information about the customer and source of funds to ensure that you have verified the customer's identity and money laundering is not involved in the transaction.
- Have the Applicant initial any and all changes. In addition, the Proposed Insured must initial all changes to questions involving insurability.
- If you accept payment with the application:
  - Complete the Conditional Receipt Agreement (CRA) if applicable.
  - For payment by check obtain a currently dated check made payable to: The Savings Bank Mutual Life Insurance Company of Massachusetts. For Automatic Payment Plan (APP) cases, two (2) months premium must be collected in order to give a CRA. The completed APP Form and voided check should accompany the application.
  - For payment by credit card complete the Authorization for Payment of Initial Premium by Credit Card Form.
  - Explain the terms and conditions of the CRA to the Owner and the Proposed Insured and have them sign it.
  - Complete and sign the Agent/Broker section on the CRA.
  - Give the Owner the COPY of the CRA. Keep the ORIGINAL with the application.
  - Promptly send the payment and the Application – Part I, including the ORIGINAL CRA to The Company.

DO NOT

- DO NOT use pencil or correction fluid.
- DO NOT attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify the contract.
- DO NOT promise or imply that we will provide insurance.
- DO NOT accept payment in the form of cash/currency or Traveler's Check.
- DO NOT accept a check made payable to you or with the payee left blank.
- DO NOT accept payment if the Proposed Insured's age nearest birthday exceeds 70 years or is under 15 days.
- DO NOT offer the CRA if the Proposed Insured is not a Standard class or better.

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4046, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

NOTICE TO PROPOSED INSURED AND OWNER (This must be given to the Proposed Insured and Owner)

Thank you for considering The Savings Bank Mutual Life Insurance Company of Massachusetts (SBLI), (referred to herein as "The Company", "We", "Us" or "Our") for your life insurance needs. We greatly appreciate your efforts to complete each part of the application truthfully and accurately. The producer should be able to answer any questions you may have. This producer is not authorized to make or modify contracts or to waive any requirements or any information that We may request. This Notice tells you what to expect after completing the Application–Part I and provides other important information required by state laws and regulations.

UNDERWRITING

Once We receive your application, We will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for insurance. We may seek information from other sources to help Us in our evaluation. During underwriting, We may find that We are unable to give you the insurance you have applied for or that We are able to give it to you only on a modified basis or at a rate greater than Our lowest rate. For example, if you have ever used any kind of tobacco or any other nicotine product, you may not be eligible for Our lowest rate.

Your application will be Our primary source of information; therefore, it must be true, complete, and accurate. You must inform Us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. A claim may be denied or your coverage may be contested by a lawsuit if the application is incomplete or if it contains fraudulent statements or material misrepresentations. If the lawsuit is successful, the policy will be void and coverage will be lost. Any policy that is delivered to you will indicate when and under what circumstances it may be contested. Please be aware that if the application contains fraudulent or deceptive statements or conceals material facts, and you submitted it with the intent to defraud or to facilitate fraud against Us, you may also be guilty of insurance fraud, which is a crime.

REPLACEMENT OF EXISTING COVERAGE

If you intend to replace existing coverage, tell the producer of your intention and answer "yes" to the replacement question in the application; state law may require the producer to give you the information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. The following could be considered replacement: you stop paying premiums on an existing policy or surrender an existing policy before or shortly after applying to Us or you borrow from an existing policy to pay premiums for the insurance for which you are applying. State law may define replacement to include other situations. Ask the producer if you are unsure.

INSURANCE INFORMATION PRACTICES

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, We may ask a consumer reporting agency to collect information and submit an investigative consumer report to Us as explained in this Notice under The Fair Credit Reporting Act. You may request to be interviewed in connection with the preparation of this report.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appear in Our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate. We will send you a more detailed explanation of Our information practices if you send Us a written request. You may send your request to: The Savings Bank Mutual Life Insurance Company of Massachusetts, P.O. Box 4046, Woburn, MA 01888.

In certain limited situations, We are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

THE FAIR CREDIT REPORTING ACT

As part of Our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living, and personal characteristics. The agency will conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to Us within a reasonable time after you receive this Notice, We will tell you whether or not a report was requested. If a report was requested, We will tell you the name, address, and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you will like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

MEDICAL INFORMATION BUREAU DISCLOSURE

Information regarding your insurability will be treated as confidential. Savings Bank Mutual Life Insurance Company of Massachusetts or its 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you my contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734.

Savings Bank Mutual Life Insurance Company of Massachusetts, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life 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.

USA PATRIOT ACT

To help the government fight the funding for terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you apply for an insurance policy or annuity contract, We will ask for your name, address, date of birth, and other information that will allow Us to identify you. We may also ask to see your driver's license or other identifying documents.

PREMIUM PAYMENTS ON TERM AND WHOLE LIFE

For premiums not paid on an annual basis at the beginning of a policy year, We adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors and associated APRs are available and will be provided. Please ask the producer for more information.

BACKDATING DISCLOSURE

You may elect to backdate your policy, which enables you to gain benefits of a lower age for the purposes of determining the premium on your policy. There are some inherent costs associated with your decision to backdate your policy. For each month that your policy is backdated, the applicable premiums are accumulated and deducted from your initial premium payment. If you choose to pay your premiums by electronic funds transfer (EFT), your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment.

PRODUCER COMPENSATION

We would like you to understand how We pay the producer. When you purchase your insurance policy from Us, We pay compensation to the producer, who represents Us for such limited purposes as taking your application, collecting your initial premium and delivering your policy, and to any intermediaries through which the producer works. This compensation may include commissions when the policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation paid will vary based on the specific circumstances of your purchase. Additionally producers and/or their intermediaries may also receive additional commissions for each year a policy remains in force, bonuses, incentive trips or prizes associated with sales contests based on sales criteria, such as overall sales volume of a producer or intermediary, or for the percentage of completed sales. Intermediaries may also pay compensation directly to the producer. If the producer can sell insurance policies from other companies, these companies may pay compensation that differs from Ours.

ELECTRONIC TRANSACTIONS

We conduct business electronically and retain your documentation in electronic format. If you prefer Us to keep original copies of your documents, please notify Us within two weeks after the submittal of your application.

ABBREVIATED NOTICE OF INFORMATION PRACTICES

- Personal information about you may be collected from other parties.
- Personal and privileged information about you may, in certain circumstances, be disclosed to third parties without your specific Authorization.
- You have the right of access to all such personal information collected and you have the right to correct any erroneous or misleading personal information.
- Upon written request, We will provide you with a Comprehensive Notice of Information practices.

SBLI
— SINCE 1907 —

TRANSMITTAL FORM

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

Proposed Insured Name: _____ Date of Birth: _____

Proposed Plan: _____ Face Amount: _____

REQUIREMENTS

Status of Requirements:	**Enclosed**
● Application	☐
● Conditional Receipt	☐
• Cash/Check.....	☐
• Credit Card	☐
● APP Authorization	☐
• Voided Check	☐

Additional Requirements:	**Enclosed**	**Ordered**	**Date Ordered:**
● Replacement Forms	☐	☐	_____
			_____
● Inspection Report	☐	☐	
● Paramedical /Medical Exam	☐	☐	_____
• Company Name: _____			
● Blood/ HOSPEC	☐	☐	_____
● HIV/Consent Form	☐	☐	_____
● EKG (exercise)	☐	☐	_____
● EKG (resting)	☐	☐	_____
● APS: Dr's Name: _____	☐	☐	_____
● Other: _____	☐	☐	_____

Special Instructions or Requests:

Agency Name: _____ Agency Number: _____

Agency Contact: _____ Agency Phone No.: _____

Contact E-Mail: _____

SBLI
— SINCE 1907 —

PRODUCER REPORT FORM

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

A. PRODUCER INFORMATION

1. Full Name (First, Middle, Last.)	2. Producer Company #
3. Phone #: Fax #: Email:	4. Managing Agency/Brokerage Name: Phone #: Fax#: Email:

B. COMPLIANCE INFORMATION

1. Have you delivered the Notice (A-91D) to the Proposed Insured and Owner?..... ☐ Yes ☐ No
2. Did you meet personally with the Proposed Insured and Owner and confirm their identification? *(If No, explain below)*..... ☐ Yes ☐ No
3. If you accepted payment with this application, a Conditional Receipt Agreement (CRA) is required. Was a CRA given?..... ☐ Yes ☐ No
4. To your knowledge, does the Owner intend to change ownership of the policy after issuance (i.e. to a trust, viatical or life insurance company or another person?..... ☐ Yes ☐ No
5. Will any portion of the premiums for this policy be financed?..... ☐ Yes ☐ No
6. Does the Proposed Insured have any existing life insurance or annuity?..... ☐ Yes ☐ No
7. Is this Insurance applied for intended to replace, end or change any existing life insurance or annuity..... ☐ Yes ☐ No

If you answered "Yes" to questions 5, 6 or 7 (above), replacement forms may be required by state law. Please include copies of any required forms with the application. If existing insurance may be replaced, ended or changed, attach a full explanation to the application and explain to the Owner and Proposed Insured that new suicide and contestable periods apply.

C. PROPOSED INSURED / OWNER INFORMATION

1. How well and how long have you known the Proposed Insured? _____
2. Are you related? ☐ Yes ☐ No If Yes, How? _____
3. If Proposed Insured is a minor, the amount of insurance on the parents are: Father _____ Mother _____
   Siblings name(s) and coverage amount(s) _____
4. If parents and siblings do not have coverage, please explain. _____

D. REMARKS

E. LICENSED PRODUCERS TO RECEIVE COMMISSION: *Please complete for each Agent to receive commission. Total commission shares to equal 100%. Each Agent will share equally unless otherwise indicated.*

Full Name	Email	% Split	Company Number

F. ACKNOWLEDGEMENT

I represent to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and the Proposed Insured in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date of the application was taken.

_____ _____
Signature of Producer Date: Signature of Second Producer (if applicable) Date:

_____ _____
Print Name of Producer Print Name of Second Producer (if applicable)

CONDITIONAL RECEIPT AGREEMENT

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com
(Referred to in this receipt as "The Company", "we", "us', or "our")

_____
Name of Proposed Insured

A. NOTICE TO PROPOSED INSURED AND OWNER

No insurance coverage will become effective before delivery of the policy applied for unless and until all of the Conditions Precedent specified in Section C of this Conditional Receipt Agreement ("Agreement") are met. If any Conditions Precedent specified in Section C, below are not met, the Producer is not authorized to accept a premium and there will be NO COVERAGE. No Producer has the authority to alter or waive the terms or conditions of this Agreement. This Agreement shall be void if altered or modified.

B. PROPOSED INSURED'S REPRESENTATIONS

1. Has the Proposed Insured:
   a. in the past 5 years, been diagnosed or treated by a medical professional for unintentional weight loss; or been advised by a medical professional of any medical condition or impairment for which he/she has not consulted a physician or medical professional for follow-up treatment? ☐ Yes ☐ No
   b. in the past 5 years been treated for, been advised to be treated for, or been diagnosed with, by a medical professional, any type of heart disease or any other vascular disease; cancer; leukemia; malignant tumor; any disorder of the immune system; stroke; or alcohol or drug dependence or abuse? ☐ Yes ☐ No
   c. in the past 90 days been admitted as an inpatient in a hospital or other licensed health care facility; or undergone any type of surgical procedure performed by a medical professional; or been advised by a medical professional to undergo diagnostic or medical testing (excluding an AIDS-related test)? ☐ Yes ☐ No
   d. been diagnosed by a medical professional as having Hepatitis C, Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

2. Is the Proposed Insured less than 15 days or more than 70 years old (age nearest birthday), on the date this Agreement is signed? ☐ Yes ☐ No

C. CONDITIONS PRECEDENT WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY

1. All of the questions in Section B of this Agreement are answered "NO"; and
2. An amount equal to the modal premium indicated on the Life Insurance Application Part I must be received by us; the mode must be either annual, semi-annual, quarterly or monthly (two months' premium required); and
3. The Life Insurance Application Part II and any required additional Application Amendments (Questionnaires), all paramedical examinations, medical testing, laboratory testing and diagnostic testing, x-rays and/or electrocardiograms initially required by us with regard to age and amount of life insurance coverage applied for and the risk class applied for must be completed; and
4. The Proposed Insured is, on the Effective Date, a risk acceptable for life insurance coverage with us exactly as applied for to us, according to our rules and practices, without modification of plan, premium rate or amount; and
5. On the Effective Date the Proposed Insured's health and all factors affecting the insurability of the Proposed Insured for coverage as applied for with us must be as stated in the Life Insurance Application Part I, the Life Insurance Application Part II and any other application supplements or amendments required by us; and;
6. Any check, authorized withdrawal, credit card payment or any form of payment must be received by us and honored when first presented for deposit by us.

D. EFFECTIVE DATE

If all Conditions Precedent specified in Section C of this Agreement are completely satisfied, then insurance coverage, subject to all the terms and conditions of the policy applied for as if the policy applied for had already been issued and delivered, will become effective as of the latest of: (a) the date the Life Insurance Application Part I is signed by Proposed Insured and received by us; (b) the date the Life Insurance Application Part II is signed by Proposed Insured and received by us; (c) the date of completion of the paramedical examinations, medical testing, laboratory testing and diagnostic testing and all of our underwriting requirements stated in Section (C)(3), above; or (d) the special policy date requested in Section J of the Life Insurance Application Part I, if any.

E. MAXIMUM AMOUNT

The maximum amount of life insurance coverage available under this Agreement shall be the lesser of: (1) the amount of insurance applied for in the Life Insurance Application Part I; or (2) $1,000,000, less the amount of insurance on the Proposed Insured's life in force with us under any policies, riders and Conditional Receipt Agreements, applied for or pending issue with us, including Accidental Death Benefits, plus the amount of any premium paid for coverage in excess of this amount; or (3) if death is due to suicide or intentional self-inflicted injury, the amount of premium paid will be refunded and no death benefit will be paid. There is no coverage under this Agreement beyond 70 years old (age nearest birthday) or below age 15 days.

F. REFUND OF MONEY

We will refund your money on the earliest of the following dates: (1) If any of the Conditions Precedent specified in Section C above are not met; or (2) You refuse to accept a policy that we issued to you; or (3) 90 days from the date this Agreement is signed. Our liability will be limited to the return of the amount paid with this Agreement. All returns will be made, without interest, to or for the benefit of the Owner. We may send a notice or return premium terminating this Agreement at any time before delivery of the policy.

_____ Name of Proposed Insured

G: AGREEMENT

I represent that all statements and answers in this Agreement are: full; complete; and true to the best of my knowledge and belief. I agree that: (1) the limited amount of insurance that may begin prior to policy delivery will not exceed the Maximum Amount as defined in Section E of this Agreement; (2) this limited amount of insurance will not begin unless all of the Conditions Precedent specified in Section C of this Agreement are completely satisfied; (3) this Agreement will be void if this Agreement or Life Insurance Application Part I or Life Insurance Application Part II contain any material misrepresentations; or if the Proposed Insured dies by suicide or intentional self-inflicted injury; and (4) this Agreement will automatically end on the earliest of the following dates: (a) the date the entire amount paid with this Agreement is returned; or (b) the date the policy applied for is delivered to the Owner; or (c) 90 days from the date this Agreement is signed. I further agree to any remaining terms, limits, and conditions of this Agreement and Life Insurance Application Part I and Part II.

I understand and expressly agree that my payment provided with this Agreement has not purchased immediate life insurance coverage under this Agreement and that no life insurance coverage under this Agreement shall commence unless and until all Conditions Precedent to life insurance coverage specified in Section C under this Agreement have been satisfied completely.

Signature of Proposed Insured	Date	Signature of Owner/Applicant (if not Proposed Insured)	Date

H: PRODUCER/BROKER STATEMENT

On the date below, I received the amount $_____ from _____ in exchange for this Agreement. This Agreement bears the same date as the Life Insurance Application – Part I. I have accurately represented the terms and conditions of this Agreement to the Proposed Insured and Owner. I know of no reason why any person to be covered may not be eligible for insurance.

Signature of Producer	Date

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER. DO NOT LEAVE THE PAYEE BLANK. CASH AND MONEY ORDERS WILL NOT BE ACCEPTED.

SBLI — SINCE 1907 —

The Savings Bank Mutual Life Insurance Company of Massachusetts
[P.O. Box 4048, Woburn, MA 01888]
Telephone [(800) 694-7254 www.sbli.com]

LIFE INSURANCE APPLICATION
Part I

In this application, "You" and "Your" refer to the Proposed Insured.

A. PRODUCT INFORMATION

1. Product	2. Face Amount	3. Riders/Additional Benefits	4. Location of Sale (city, state)
❑ Level Term: ❑ 10Yr ❑ 15Yr ❑ 20Yr ❑ 25Yr ❑ 30Yr ❑ Whole Life: ❑ SL ❑ L10 ❑ L15 ❑ L20 ❑ L@65 ❑ SPL ❑ YRT ❑ Other_____		❑ Term Insurance Rider Plan_____ $_____ ❑ Child Insurance Rider $_____ ❑ Waiver of Premium Rider ❑ Other:_____	

B. PROPOSED INSURED INFORMATION

1. Full Name (First, Middle, Last. Include maiden name)	2. Sex ❑ M ❑ F	3. Date of Birth (mm/dd/yyyy)	4.Birth State & Country	5. SSN

6. Home Address (Number, Street, City, State, Zip Code)	7. Phone and Email: Home #: Cell#: Work#: Email: Preferred method of contact:

8. Driver's License Number State Issued:	9. Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Single ❑ Widowed # of dependents: Ages:	10. U.S. Citizen? ❑ Yes ❑ No *(If "No", complete the Citizen Questionnaire and attach copy of green card or visa)*

11. Occupation *(include duties)*	12. Employer Name and Address	13. How long employed?

14. Have you ever used tobacco or any other nicotine product or by-product of any type? ❑ Yes ❑ No
If "Yes"; Type: How long used: Last used: (mm/yyyy)
Amount & Frequency:

15. How much life insurance does your spouse have in force with all insurers, including SBLI? $
Is your spouse also applying for insurance with SBLI? ❑ Yes ❑ No If "Yes", how much? $

C. OWNER/APPLICANT INFORMATION *Complete only if Owner is to be other than the Proposed Insured. If Trust, give full name of Trust and date of Trust agreement.*

1. Type: ❑ Individual ❑ Corporation ❑ Trust ❑ Sole Proprietorship ❑ Partnership ❑ Other (Specify):

2. Owner/Applicant/Trust Name	3. Date of Birth/Trust (mm/dd/yyyy)	4. Relationship to You	5. SSN/TIN

6. Residence Address (Number, Street, City, State, Zip Code)	7. Email	8. Phone Numbers:

9. Billing Address (Number, Street, City, State, Zip Code)	10. State Incorporated	11. Purpose of Trust

12. Trust Contact Name	13. Type of Trust ❑ Revocable ❑ Irrevocable	14. Name of Trustee(s)/Corporate Officer

15. Does the above Trustee have sole authority to act on behalf of the Trust? ❑ Yes ❑ No (*If "No", list the names and addresses of all Trustees and obtain their signatures below. Attach a separate page, if necessary.)*

Trustee's Name	Address	Signature

Name of Proposed Insured

D. BENEFICIARY INFORMATION *If percentages are not given, shares will be distributed equally. Total percentage of primary beneficiaries' shares must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Attach separate sheet for additional beneficiaries.*

1. Primary Beneficiaries

Full Name	Address	Date of Birth	SSN or TIN	Relationship to You	% Share

2. Contingent Beneficiaries

Full Name	Address	Date of Birth	SSN or TIN	Relationship to You	% Share

3. If the beneficiary is a Trust or Corporation, provide name and date created:

Name of Trust/Corporation List Trustees if applicable	Date of Trust	State Incorporated

E. PROPOSED INSURED INSURANCE NEEDS *Complete either the Personal or Business Section. Explain "Yes" answers in the Remarks Section.*

Personal Section

1. Purpose of Insurance: ☐ Income Replacement ☐ Debt Repayment ☐ Estate Conservation ☐ Other (Specify):

2. Gross Annual Income $	3. Household Income $	4. Net Worth $	5. Within the last 5 years, have you filed for bankruptcy or had any judgments or liens filed against you? ☐Yes (Date of Discharge:) ☐No

Business Section

6.Purpose of Insurance: ☐ Buy-Sell ☐ Key Employee ☐ Secure Credit ☐Other (Specify):	7. Is the business a: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other
8.Type of Business	9. How long has the business been established?

10. Total Liabilities $	11. Net Worth $	12. Within the last 5 years, has the business filed for bankruptcy or had any judgments or liens filed against it? ☐ Yes (Date of Discharge) ☐ No

13. Net Profit after taxes for the past two years: Last Year: $ Previous Year: $	14. What % of the business is owned by you?	15. Your gross annual income with bonuses: $	16. Amount of business insurance in force on your life: $

17.In the Remarks section (J):
a. If applicable, describe any insurance being applied for or in force on other key members of the business.
b. If applicable, describe why there is no insurance being applied for or in force on other key members of the business.

F. PROPOSED INSURED PERSONAL HISTORY

1. Have you ever sold a policy or been involved in any discussions about the possible sale or assignment of this policy to a life settlement, viatical or other secondary market Provider/Producer? *(If "Yes", provide details below)*…… ☐Yes ☐ No
2. Do you have any other applications or informal inquiries for life insurance pending with any other company, society or association in the last 12 months? *(If "Yes", provide details below)*..... ☐Yes ☐ No
3. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited, withdrawn, or cancelled, or have you been asked to pay a higher premium? *(If "Yes", provide details below)*…… ☐Yes ☐ No
4. Have you, in the last 3 years, resided or traveled, or do you intend to reside or travel, outside of the United States? *(If "Yes", complete the Foreign Travel Questionnaire*)…… ☐Yes ☐ No
5. In the last 3 years, has your driver's license been suspended or revoked, or have you received any moving violations? *(If "Yes", provide details below)*…… ☐Yes ☐ No

Name of Proposed Insured

6. Have you ever been convicted of reckless driving, driving to endanger or driving under the influence of drugs or alcohol? *(If "Yes", provide details below)*…….. ☐Yes ☐ No
7. Except for traffic violations, have you been the subject of, or been convicted of, a misdemeanor or felony, or are you awaiting trial for a felony? *(If "Yes", provide details below)*……..... ☐Yes ☐ No
8. Have you in the last 3 years engaged in, or do you intend to engage in, flying a plane, racing motor boats or motor vehicles, or participate in sky-diving or parachuting, hang-gliding, hot air ballooning, mountain, rock or ice climbing, scuba diving or other hazardous activities? *(If "Yes", complete the appropriate Hazardous Activities and/or Aviation Questionnaire)* …… ☐Yes ☐ No
9. Are you currently or intend to become a member of the Armed Forces, including the Reserves or National Guard? *(If "Yes", complete the Military Questionnaire)*…….. ☐Yes ☐ No

For any "Yes" answers, record details below: Use the overflow sheet if needed.

Question #	Explanation

G. PREMIUM PAYMENT INFORMATION *(If "EFT" or "Credit Card", please fill in the EFT or Credit Card form. Credit Card available only for Initial Payment)*

1.Initial Payment:	2.Payment Mode:	3.Send Premium Notices to:
☐ Check ☐ COD ☐ Credit Card	☐ Annual ☐ Semi-Annual	☐ Insured ☐ Owner
☐ Electronic Fund Transfer (EFT) ☐ Other (Specify):	☐ Quarterly ☐ Monthly (EFT only)	☐ Other (Specify):

4. Amount paid with Conditional Receipt Agreement (CRA): $

5. Would you like to backdate your policy to save age? *(If "Yes", see Backdating Disclosure section in the Notice to Proposed Insured and Owner)*……. ☐ Yes ☐ No

H. DIVIDEND OPTIONS *(If none selected or a selected option is not available, the default option will be Accumulate at Interest – Not applicable if policy applied for is Non-Participating)*

1. ☐ Pay in Cash (check)
2. ☐ Reduce amount due – any excess as: ☐ #4 ☐ #3 ☐ #1
3. ☐ Purchase Paid Up Life Additions
4. ☐ Accumulate at interest

OR

5. ☐ Not applicable (Non-Participating)

ADDITIONAL SERVICES

While your Policy is In Force, and if available on the product you elect, we may provide you with access to additional services such as cloud-based document storage.

I. REPLACEMENT INFORMATION *Applies to both Owner and Proposed Insured.*

If you intend to replace existing coverage, please tell the Producer of your intention and answer "Yes" to replacement question #2 below. State law may require the Producer to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain, among other things, new suicide exclusions and contestability periods. Ask the Producer if you are unsure.

	Proposed Insured	Owner
1. Do you have an existing or pending life insurance policy or annuity contract? *(If "Yes", provide details below. Complete state required replacement form for New NAIC Model Replacement Regulation States only)*	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you intend to replace any existing life insurance or annuity contract? *(If "Yes", complete state required replacement form and provide details below)*	☐ Yes ☐ No	☐ Yes ☐ No
3. Are you considering using funds from an existing policy or contract to pay premiums on the policy you are applying for? *(If "Yes", complete state required replacement form and provide details below)*	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you stopped making premium payments, surrendered, forfeited, assigned to the Company, or otherwise terminated an existing policy or contract or are you considering doing so? *(If "Yes", complete state required replacement form and provide details below)*	☐ Yes ☐ No	☐ Yes ☐ No

Insurance Companies (Do not include group policies)	Name of Insured	To be replaced?	Contract / Policy #	Cash Value / Amount of Coverage	Date Issued
		☐ Yes ☐ No		$	
		☐ Yes ☐ No		$	
		☐ Yes ☐ No		$	

J. REMARKS *(Use this section for explanations and special requests. Identify applicable Question and Section numbers.)*

Name of Proposed Insured	Social Security Number	Date of Birth

K. AUTHORIZATION TO COLLECT AND DISCLOSE INFORMATION

This Authorization complies with the Health Insurance Portability and Accountability Act ("HIPAA")

I hereby authorize all the entities listed below that have provided payments, treatments or services to me, or on my behalf, to disclose to The Savings Bank Mutual Life Insurance Company of Massachusetts (the "Company") and its reinsurers, Producers, employees and representatives, including insurance support organizations, the following information: any and all information relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of alcohol, drugs, and tobacco; drug prescriptions and communicable diseases, including Human Immunodeficiency Virus (HIV) and AIDS, and any other personal information about me.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner or health care professional;
- any hospital, laboratory, pharmacy, pharmacy benefit manager, clinic or other health care facility or provider;
- any insurance or reinsurance company;
- any consumer reporting agency or insurance support organization; and
- my employer, group policy holder, or benefit plan administrator

This information may be disclosed pursuant to this Authorization so that the Company can use it to:

- determine my eligibility for insurance;
- underwrite my application and make risk rating, policy issuance and enrollment determinations;
- determine my eligibility for benefits under the Conditional Receipt Agreement;
- obtain reinsurance;
- if a policy is issued, administer coverage, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and
- conduct other legally permissible activities that relate to any insurance coverage I have or have applied for with the Company.

- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, medical practitioner, health care provider, hospital, clinic or any other health care provider to release and disclose my entire medical record without restriction except for any portion that may involve testing for Human Immunodeficiency Virus (HIV) not related to prior testing for the purpose of obtaining insurance. I understand that my health care providers can not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.
- I authorize the Company and its reinsurers to release any information obtained by this Authorization to other insurers in which I have policies or to which I may apply or to which a claim for benefits may be submitted, to reinsurers, and to other persons or organizations performing legal or business services in connection with my application or claim.
- I authorize MIB, Inc., and any MIB member insurer, to provide any medical or personal information that it has about me to the Company and its reinsurers or any MIB-authorized third-party administrator performing underwriting services on behalf of the Company. I also authorize the Company, its reinsurers or authorized third-party administrator, to make a brief report of my personal health information to MIB, Inc.
- I authorize the Company to release to me, or to my physician, results that I may request of any medical or laboratory tests taken in connection with this application. In connection with a claim for benefits, this Authorization is valid no longer than the duration of the claim.
- I also understand that failure to sign this Authorization statement, or subsequent revocation of this Authorization by me, may impair the ability of the Company to process my application or evaluate claims, and may be a basis for denying an application or claim for benefits.
- I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.
- By signing below I agree to the terms of this Authorization and acknowledge that I have read and understand it.

I may revoke this Authorization in writing at any time, except to the extent that action has been taken in reliance of this Authorization or to the extent the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself, by sending a written request to: The Savings Bank Mutual Life Insurance Company, P.O. Box 4048, Woburn, MA 01888.

This Authorization shall remain in force for 24 months following the date of my signature below or for the duration of any claim for benefits. A copy of this Authorization is as valid as the original. I acknowledge that I have received a copy of this Authorization.

Date: _____ Signature of Proposed Insured (Parent, Guardian, Other*): X_____

*If the insured is under the age of 18, signature of ❑ Parent ❑ Guardian ❑ Other: _____

Name of Proposed Insured

M. REPRESENTATIONS

I, the Owner and the Proposed Insured signing below, agree that I have read the statements contained in the application or they have been read to me. I understand that the application includes the Application – Parts I and II and all supplemental forms or amendments the Company specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner.

I acknowledge that my answers to the above questions may result in higher premium rates or a denial in coverage.

I understand and agree that no Producer is authorized to (a) accept risks or pass upon insurability; (b) make or modify contracts; (c) waive the Company's rights or requirements; or (d) waive any information the Company requests.

I represent: (1) that the statements and answers I provided within the entire application are true, complete, and correct to the best of my knowledge and belief; (2) that the Company, believing the statements and answers to be true, complete, and correct, shall rely and act on them (3) the insurance being applied for is suitable for the Owner's insurance needs.

Under penalty of perjury, I certify that : a) the number shown is my correct taxpayer identification number and b) I am not subject to backup withholding because 1) I am exempt from backup withholding, or 2) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or 3) the IRS has notified me that I am no longer subject to backup withholding. The IRS does not require your consent to any provision of this document other than certification required to avoid backup withholding.

CROSS OUT ALL OF SUBPART "b)" IN THE PRECEDING PARAGRAPH IF YOU ARE SUBJECT TO BACKUP WITHHOLDING.

FRAUD WARNING

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

ACKNOWLEDGEMENT AND SIGNATURES

I acknowledge that I have received a copy or I have been read a copy of the Notice to Proposed Insured and Owner.

I agree that:
(a) I will notify the Company if any statement or answer given in the entire application changes prior to policy delivery; and
(b) except as provided in the Conditional Receipt Agreement (CRA), I understand and agree that even if I paid a premium, no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless the following three conditions are all met:

(1) the policy has been delivered and accepted;
(2) the full first modal premium for the delivered policy has been paid in full; and
(3) there has been no change in the health of the Proposed Insured that would change the answers to any questions in the application, or any amendments thereto, before conditions (1) and (2) above have occurred.

I understand and agree that if all three conditions are not met:
- no insurance coverage will become effective; and
- the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

Signature of Proposed Insured	Date	Signature of Owner/Applicant (if not Proposed Insured)	Date
X_____		X_____	
Signature of Producer	Date	Signature of Producer	Date
X_____		X_____	
Producer Name Printed		Producer Name Printed	

	License #	Producer #		License #	Producer #

Rate applied for:

The Company reserves the right to make administrative changes to the application. No administrative changes will be ascribed to the applicant.

_____

Name of Proposed Insured

N. PRODUCER INFORMATION and PRODUCER CERTIFICATION

1. Does the Applicant have existing life insurance policies or annuity contracts? ❑ Yes (Submit the state applicable replacement form) ❑ No
2. Do you have any knowledge or reason to believe that a replacement of an existing life insurance policy or annuity contract is involved in this transaction or that any funds from an existing policy or contract will be used to pay premiums on this applied for policy? ❑ Yes ❑ No
3. Do you have any knowledge or reason to believe that the proposed Owner or Applicant intends to change ownership of the policy now or in the future to an unrelated party such as a trust, viatical, life settlement company, bank and/or lending or investment company? ❑ Yes ❑ No
4. Do you have any knowledge or reason to believe that all or any part of the initial or future premium payments for this applied for policy may be directly or indirectly financed by an unrelated third party or be part of any loan arrangement? ❑ Yes ❑ No
5. Do you have any knowledge or reason to believe that the proposed Owner, Applicant or Insured has been offered any financial incentives as an inducement to apply for this proposed policy? ❑ Yes ❑ No
6. Have you received relevant anti-money laundering training within the last 24 months that was offered by the company, another life insurance company or a competent third party (e.g., LIMRA)? ❑ Yes ❑ No
7. Do you acknowledge that you are in compliance with your requirements as stated in the company's Producer's Guide to Anti-Money Laundering (AML) and are unaware of any AML Red Flags as described in your AML training? ❑ Yes ❑ No

I certify that the responses herein are, to the best of my knowledge, information and belief complete and accurate.
I certify that this policy has not been solicited, directly or indirectly for the benefit of an investor, stranger or unrelated third party.
I certify that I am duly licensed in the state in which this application was signed.
I have given the Proposed Insured the appropriate disclosure documents and have complied with state and federal statutes and regulations.
I have reviewed the purchase of the life insurance policy as to suitability.

X_____ _____ _____

(Producer's Signature) (Producer's Printed Name) (Date)

Lead #: Underwriting Stamp
Source:
Rate Code:
Process Date:

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

SUPPLEMENT TO LIFE INSURANCE APPLICATION
Part I

Name of Proposed Insured	Date of Birth	Social Security Number	Date of Application

Additional Details *(Use this space for explanations to any answers provided in application Part 1, or for any special requests. Identify applicable Question and Section numbers.)*

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Signature of Proposed Insured	Date	Signature of Owner/Applicant (if not Proposed Insured)	Date
Signature of Producer	Date	Signature of Producer	Date
Producer Name Printed		Producer Name Printed	

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INDIVIDUAL LIFE INSURANCE APPLICATION
Part II

A. PROPOSED INSURED INFORMATION

1. Full Name (First, Middle, Last)	2.Date of Birth (mm/dd/yyyy)	3. SSN

4. Build

a. Height	b. Weight	c. Have you had any weight changes in excess of 10lbs. in the past year? ❑Yes ❑No
ft. in.	lbs.	If Yes: Pounds Lost_____Pounds Gained_____Reason_____

d. Have you had any surgical treatment for weight loss? ❑Yes ❑No

If yes: Date of Surgery____/____/_____Describe_____

5. Do you have a personal Physician or health care provider? ❑Yes ❑No
If yes: Please provide the name of your Primary Personal Physician or health care provider that would have your up to date medical information. If more than one personal physician, provide name(s) in DETAILS section.

a. Physician/Health Care Provider	b. Address

c. Phone Number	d. Date Last Consulted	e. Reason

6. Was your last medical consultation with a physician or specialist other than your personal physician? ❑Yes ❑No
If yes: Please provide the name of your Physician or health care provider you last consulted, if different from the above. *If more than one, provide name(s) in DETAILS section.*

a. Physician/Health Care Provider	b. Address

c. Phone Number	d. Date Last Consulted	e. Reason

B. MEDICAL INFORMATION Please *answer ALL medical history questions. Do not leave any questions blank. Explain "Yes" Answers in DETAILS*

1. Have you ever been advised by a licensed member of the medical profession that you had or currently have any of the following:

a. Cancer, tumors; cysts; growths or polyps or any disorder of the skin?	❑Yes ❑No
b. Depression, anxiety, attention deficit/hyperactivity, suicidal thoughts or attempts, anorexia or bulimia, or any other psychological, psychiatric, emotional, or mental disorders?	❑Yes ❑No
c. High blood pressure, chest pain, heart attack, coronary artery disease, heart valve disorder, heart murmur, stroke/transient ischemic attack, irregular heart beat, peripheral vascular disease, aneurysm or any other disease or disorder of the heart or circulatory system?	❑Yes ❑No
d. Asthma, bronchitis, pneumonia, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, shortness of breath, or any other disease or disorder of the lungs or respiratory system?	❑Yes ❑No
e. Colitis, Crohn's disease, hepatitis, cirrhosis, or any other disease or disorder of the liver, pancreas, gallbladder, esophagus, stomach, or intestines?	❑Yes ❑No
f. Epilepsy, multiple sclerosis, Parkinson's disease, paralysis, Alzheimer's, dementia, memory loss, headaches, dizziness or fainting, or any other disease or disorder of the brain, nervous system, or neuro-muscular disorder?	❑Yes ❑No
g. Diabetes, high blood sugar, glucose intolerance, thyroid or pituitary disorder, elevated cholesterol or other lipid disorder, or any other endocrine disease or disorder?	❑Yes ❑No
h. Disorder of kidney, bladder, prostate, blood or protein in the urine, or any disease or disorder of the genitourinary system?	❑Yes ❑No
i. Disorder of breast or reproductive organs?	❑Yes ❑No
j. Arthritis or any other disease or disorder of the muscles, bones, spine, or joints?	❑Yes ❑No
k. Anemia, coagulation or clotting disorder, or any other disease or disorder of the blood or lymph nodes?	❑Yes ❑No
l. Lupus, autoimmune disease or disorder, or connective tissue disease?	❑Yes ❑No

Name of Proposed Insured

2. Are you currently receiving medical treatment or taking any other medication from a licensed member of the medical profession that has not already been disclosed?	❑Yes ❑No
3. Do you have any doctor's visits, medical tests, medical care, or surgery recommended or scheduled by a licensed member of the medical profession that has not been completed (excluding HIV)? If yes, please provide details.	❑Yes ❑No
4. During the past 5 years, have you:	
a. Had an electrocardiogram, x-ray, blood test, or other diagnostic test excluding HIV test?	❑Yes ❑No
b. Requested or received disability or compensation benefits?	❑Yes ❑No
5. Have you ever been diagnosed by a licensed member of the medical profession with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	❑Yes ❑No
6. Have you ever:	
a. Used heroin, cocaine, crack, marijuana, ecstasy, PCP, LSD, amphetamines, barbiturates, opiates, or other illegal controlled or restricted substances except as prescribed by a licensed member of the medical profession, or been advised by a licensed medical professional to seek treatment for addiction to prescription medication?	❑Yes ❑No
b. Been advised, counseled, or received help or treatment by a licensed medical practitioner, or attended any organization to limit or discontinue the use of alcoholic beverages?	❑Yes ❑No
7. How many alcoholic drinks do you consume per week? ___	
8. Family History	
a. Has a parent or sibling ever been diagnosed or treated by a licensed medical professional for coronary artery disease, cardiovascular disease, cerebrovascular disease, stroke, or cancer under the age of 60?	❑Yes ❑No
b. Please complete the following:	

	Age if Living	Age at Diagnosis	Age at Death	Cause of Death
Father				
Mother				
❑ Brother ❑ Sister				
❑ Brother ❑ Sister				
❑ Brother ❑ Sister				
❑ Brother ❑ Sister				
❑ Brother ❑ Sister				
❑ Brother ❑ Sister				

C. DETAILS *For any "Yes" answers. Identify applicable question. If additional space is needed, use overflow form.*

State conditions, diagnoses, dates, durations, treatments, tests, medications prescribed and names, phone numbers and addresses of all care providers and treatment facilities.

…

Name of Proposed Insured

D. AGREEMENT AND SIGNATURES

I, the Proposed Insured signing below, agree that I have read all of the statements contained in this entire application, or they have been read to me
I understand and agree that no Producer is authorized to (a) accept risks or pass upon insurability; (b) make or modify contracts; (c) waive The Savings Bank Mutual Life Insurance Company of Massachusetts's ("the Company'")s rights or requirements; or (d) waive any information the Company requests.

I represent: (1) the statements and answers given in the entire application are true, complete, and correct to the best of my knowledge and belief; (2) that the Company, believing the statements and answers to be true, complete, and correct, shall rely and act on them, and (3) the insurance being applied for is suitable for the Owner's insurance needs.

I acknowledge that I have received a copy or I have been read a copy of the Notice to Proposed Insured and Owner.

I agree that:
(a) I will notify the Company if any statement or answer given in the entire application changes prior to policy delivery; and
(b) except as provided in the Conditional Receipt Agreement (CRA), I understand and agree that even if I paid a premium, no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless the following three conditions are all met:

(1) the policy has been delivered and accepted;
(2) the full first modal premium for the delivered policy has been paid in full; and
(3) there has been no change in the health of the Proposed Insured that would change the answers to any questions in the application, or any amendments thereto, before conditions (1) and (2) above have occurred.

I understand and agree that if all three conditions are not met:
- no insurance coverage will become effective; and
- the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

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

Signature of Proposed Insured	Date	City, State
X_____		

E. SIGNATURE(S) OF INTERVIEWER(S) – TO BE SIGNED BY ALL INTERVIEWERS, AS APPLICABLE

I certify that the information supplied by the Proposed Insured has been truthfully and accurately recorded on the Part II application.

If Producer recorded information:

Writing Producer Name	Date	Writing Producer Number

Writing Producer Signature	Countersigned (Licensed resident Producer if state required)
X_____	X_____

If Tele-interviewer recorded information:

Name	Date

If Paramedical recorded information:

Examiner's Name	Date	Phone Number

Signature of Examiner	Date	City, State
X_____		

_____ Name of Proposed Insured

F. CUSTOMER IDENTITY INFORMATION : To be completed by Producer or Paramed in physical proximity to the Proposed Insured (and Owner if different than Insured). I have reviewed the Proposed Insured and Owner's (if applicable) identity document presented and recorded the following information:		
Proposed Insured (and Owner if applicable) Name:		
Street Address:	City and State:	Zip Code:
Type of ID (Individual) (e.g. Drivers License):		
Type of ID Document (Corporation/Trust) (e.g. Certificate of Good Standing or Trust):		
ID Number:	Expiration Date:	
Signature of Producer or Paramed Authenticating Customer's Identity: X_____		
Producer/Paramed Number	Date:	

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

SUPPLEMENT TO LIFE INSURANCE APPLICATION PART II

Name of Proposed Insured	Date of Birth	Social Security Number	Date of Application

I hereby request that the application on the life of the Proposed Insured be amended to include the following:

C. DETAILS *For any "Yes" answers. Please identify applicable Question.*

State conditions, diagnoses, dates, durations, treatments, tests, medications prescribed and names, phone numbers and addresses of all care providers and treatment facilities.

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Signature of Proposed Insured	Date	City, State
If Producer recorded information:		
Signature of Writing Producer	Date	City, State
If Tele-interviewer recorded information:		
Name		Date
If Paramedical recorded information:		
Examiner's Name	Date	Phone Number

The Savings Bank Mutual Life Insurance Company of Massachusetts
One Linscott Road, Woburn MA 01801
Telephone (800) 694-7254 ~ www.sbli.com

NOTICE AND CONSENT FOR AIDS VIRUS (HIV) BLOOD (OR OTHER BODY FLUIDS) TESTING

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood or other bodily fluids for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

AIDS: Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from infected mother to her newborn infant or by exposure to infected blood (as in needle sharing during intravenous drug use.) Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs and sexual contacts of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

Pre-Testing Considerations: Many public health organizations have recommended that before taking an AIDS-related blood or other bodily fluids test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Test: Tests may be performed to determine the presence of antibodies to Human Immunodeficiency Virus (HIV); the tests do not detect the presence of the AIDS virus. These tests include an enzyme-linked immunosorbent assay (ELISA) serologic test and the Western Blot Assay. Both of these tests have been approved by the Federal Food and Drug Administration, are extremely reliable and false positive reports are rare. If a person's initial ELISA test is positive, that test will be repeated. If the repeat ELISA also results in a positive report, the Western Blot Assay will be performed. A person will be considered to have the HIV antibodies present in his/her bodily fluids(s) only after positive results on two ELISA tests and a Western Blot.

Meaning of Positive Test Result: The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

You should be aware that a positive test result will result in the denial of your application for insurance.

Confidentiality of Test Results: All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test result may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be made known to the Medical Information Bureau, Inc. (MIB). The MIB operates as an information exchange on behalf of its life and health insurance company members under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result: If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician so that he or she may tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:

_____

Physician's Address:

_____

If you have not given written consent authorizing a physician to receive positive test results, you will be urged, at the time you are informed of positive test results, to contact a private physician, the County Department of Health, the State Department of Health, local medical societies or alternative test sites for appropriate counseling (below is a list).

Consent: I have read and I understand this Notice and Consent for HIV-Related Blood (or Other Bodily Fluids) Testing. I voluntarily consent to the withdrawal of blood or other bodily fluids from me, the testing of that blood or other bodily fluids, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This authorization expires six months from the date it is signed.

_____	_____	_____
Print Name of Proposed Insured	Signature of Proposed Insured or Parent/Guardian	Date

Address: _____

_____

California AIDS Counseling Facilities

AIDS Project – East Bay 1755 Broadway 2nd Floor Oakland, CA 94612 (510) 457-4022	**AIDS Project - Los Angeles** 3550 Wilshire Boulevard Suite 300 Los Angeles, CA 90010 (213) 201-1388
AIDS Service Foundation of Orange County 17982 Sky Park Circle Suite J Irvine, CA 92614 (949) 809-5700	**ARIS Project** 380 North First Street San Jose, CA 95112 (408) 293-2747
Central Valley AIDS Team P.O. Box 4640 Fresno, CA 93744 (209) 264-2437	**Sacramento AIDS Foundation** P.O. Box 161418 Sacramento, CA 95816 (916) 448-2437
San Diego AIDS Project 2440 Third Avenue San Diego, CA 92101 (619) 235-6151	**San Francisco AIDS Foundation** 995 Market Street Suite 200 San Francisco, CA 94103 (415) 487-3000

IMPORTANT NOTICE TO INSURANCE CUSTOMERS

- The insurance product or annuity you are considering purchasing is not a deposit or other obligation of, or guaranteed by the bank or any of its affiliates.

- This insurance product or annuity is not insured by the FDIC, any other agency of the United States, or the bank and its affiliates.

- If the insurance product or annuity you are considering purchasing contains investment risk there is a possibility that it may suffer a loss of value. Variable insurance products contain this risk.

I hereby acknowledge that I have reviewed the above disclosures with the sales representative or agent and have been provided an opportunity to discuss any questions that I may have had.

_____ _____

Customer Signature Date

☐ The above disclosures were provided orally to the customer.

_____ _____

Agent Signature Date

The Savings Bank Mutual Life Insurance Company of Massachusetts

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

CERTIFICATE OF NO ILLUSTRATION

This form applies only to whole life, universal life, or yearly renewable term life policies.

This form is to be completed at the time of, and submitted with, the Application when no sales illustration is presented to the Applicant when selling a life insurance policy, or when the Applicant applies for a policy other than as illustrated.

APPLICANT'S CERTIFICATION AND SIGNATURE

By signing, I acknowledge that:

(a) no life insurance sale illustration has been given to me for the policy for which I have currently applied; and

(b) I understand that an illustration conforming to any policy that may be issued will be provided on or before the delivery of such policy.

Signature of Proposed Insured	Date	Signature of Owner/Applicant (if not Proposed Insured)	Date
X_____		X_____	

PRODUCER'S CERTIFICATION AND SIGNATURE

By signing, I certify that I did not present an illustration to the Applicant that conforms to the policy applied for.

Signature of Producer	Date	Signature of Producer	Date
X_____		X_____	
Producer Name Printed		Producer Name Printed	
License # / Producer #		License # / Producer #	

The Savings Bank Mutual Life Insurance Company of Massachusetts
One Linscott Road, Woburn MA 01801
Telephone (800) 694-7254 ~ www.sbli.com

NOTICE AND CONSENT FORM
EMPLOYER-OWNED LIFE INSURANCE

The Pension Protection Act of 2006 (effective for policies issued on or after August 18, 2006, as well as policies issued before that date that undergo material increases in death benefits) places certain requirements on employer-owned life insurance policies for the death benefit proceeds to remain income tax-fee. Employers must provide notice to the employee concerning the purchase of life insurance and the employee must provide written consent to the employer before any policy is issued. There are record keeping requirements also imposed upon the employer.

Legal Name of Employer (hereinafter "the Company"): _____

Name of Employee/Director (Proposed Insured): _____

Gender: _____ Date of Birth: _____ Social Security Number: _____

Home Address: _____
(Street) (City or Town) (Zip Code)

Business Address: _____
(Street) (City or Town) (Zip Code)

Check One of the Following:

❑ I consent to have life insurance purchased on my life for the benefit of the Company named above, and I acknowledge that the Company has an insurable interest on my life. The maximum face amount for which my life can be insured has been explained to me. I have received a written explanation from the Company, understand the reason(s) for this life insurance coverage and agree to have insurance placed on my life. I agree that the Company will have all of the rights of ownership, will pay all premiums, and will be the named beneficiary of the life insurance policy. I understand and agree that my administrators, estate, heirs, and assignees have no rights to any policy proceeds or benefits, unless specifically agreed otherwise in a separate written agreement between the Company and me. I further understand that the Company may keep the life insurance policy, or policies, in effect on my life after my employment (or service as Director) with the Company has ended.

❑ I do not consent to have life insurance placed on my life by the Company. I understand that my declining to provide consent will not adversely affect my employment (or my service as Director).

_____ _____ _____
(EMPLOYEE/DIRECTOR NAME) (EMPLOYEE/DIRECTOR SIGNATURE) (DATE)

Important Note: This form is provided as a convenience to the employer and to obtain information that may be needed for information reporting purposes. By providing this form, SBLI of Massachusetts makes no representation that completing it will constitute compliance with any law or regulation, tax or otherwise. Federal tax law specifies that the death benefit proceeds of certain employer owned life insurance policies will not be completely excluded from federal gross income of the employer unless notice and consent requirements and other requirements specified in the law are fulfilled. Any information concerning tax issues is not intended (and cannot) be used by anyone to avoid IRS penalties. It is merely intended to support the sale of life insurance products. Clients should always seek tax advice based on their particular circumstances from an independent tax advisor.

The Savings Bank Mutual Life Insurance Company of Massachusetts
One Linscott Road, Wobun MA 01801
Telephone (800) 694-7254 ~ www.sbli.com

LIFE INSURANCE AND ANNUITY DISCLOSURE FOR OWNER 65 YEARS OF AGE AND OLDER

The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation, and that the elder or elder's agent may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale, or sold.

-Applicant's Acknowledgement-

I have read and understand the above statement.

_____ _____ _____

(Applicant's Printed Name) **(Applicant's Signature)** **(Date)**

-Agent Offering to Sell Life Insurance Policy or Annuity Contract-

_____ _____ _____

(Agent's Printed Name) **(Agent's Signature)** **(Date)**

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Third Party Designation Request

Insured's Name:		Policy Number(s):	
Owner's Name:			Day Phone:
Street Address:	City, State:	Zip Code:	Email:

You can take additional steps to ensure your policy does not lapse due to non-payment of premiums. With this form, you are able to designate another party to receive any notice of overdue premiums or policy lapse. This allows you to make sure that another party has been informed that there is a pending lapse of your life insurance policy. That party can take action to protect your policy. At any time you can change or cancel your designation. This Third Party Notice of Lapse will be in addition to the notice of lapse that we send to you.

This designation shall not constitute acceptance of any liability on the part of the Third Party or The Savings Bank Mutual Life Insurance Company of Massachusetts for services provided to the policyholder.

Third Party Designation			
Designee's Name:			Day Phone:
Street Address:	City, State:	Zip Code:	Email:

I hereby request that the above named person be notified of any policy lapse as described above.

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_____ _____ _____

Print Name of Owner **Signature of Owner** **Date Signed**

POLICY E-APPLICATION & E-DELIVERY AUTHORIZATION & DISCLOSURE

For your convenience, The Savings Bank Mutual Life Insurance Company of Massachusetts ("SBLI") offers an electronic application ("e-application") process as well as the optional electronic delivery[1] ("e-delivery") of your policy. Please read the following terms and conditions regarding these services, then confirm your agreement by clicking the appropriate box(es) and signing and dating this form in the allocated space below.

- Your consent to completing your application electronically, receiving any related documents electronically and the e-delivery of your policy is voluntary as you may withdraw your consent or request a paper copy of your policy by calling Customer Service at 1-800-694-7254 or emailing SBLI at records@sbli.com. Your consent here only applies to your e-application, receipt of any related documents electronically and the e-delivery of your policy. These services also require internet access and software enabling you to open & save pdf documents. Free pdf software is available at https://get.adobe.com/reader/.

- Should you have any additional questions or concerns regarding your e-application, the e-delivery of your policy or if your email address changes please contact SBLI by emailing us at records@sbli.com or calling Customer Service at 1-800-694-7254.

☐ I consent to completing my application and receiving any related documents electronically.

☐ I consent to the e-delivery of my policy.

By signing below, I confirm that: I can access and read this POLICY E-APPLICATION & E-DELIVERY AUTHORIZATION & DISCLOSURE; I can print, save or send this document to a secure place for future access; and until or unless I notify SBLI as described above, I hereby consent to the electronic transactions I selected above.

X_____
Signature & Date

_____
Email Address

[1] Not all policies are eligible for e-delivery. Policies ineligible for e-delivery may include, but are not limited to: policies where the policy owner is different from the proposed insured; policies with incomplete application forms or missing signatures; policies with invalid or incorrect customer email addresses.