SBLI® THE NO NONSENSE LIFE INSURANCE COMPANY®

LIFE INSURANCE APPLICATION
Part I

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

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 ☐ Electronic Fund Transfer (EFT) ☐ Other (Specify):	☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (EFT only)	☐ Insured ☐ Owner ☐ 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 OR 5. ☐ Not applicable (Non-Participating)
3. ☐ Purchase Paid Up Life Additions 4. ☐ Accumulate at interest

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 Life Insurance Company of Massachusetts (the "Company") and its 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;
- my employer, group policy holder, or benefit plan administrator; and
- MIB, Inc. (MIB)

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. 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 further authorize the Company to release any information obtained by this Authorization to MIB, 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 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.
- 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.
- By signing below I agree to the terms of this Authorization and acknowledge that I have read and understand it.

FOR MAINE and VERMONT APPLICANTS, this Authorization excludes the release of any information relating to previously administered test for HIV antibodies, T-Cell counts, AIDS or ARC, by the applicants family/regular/attending medical doctor/physician/practitioner or care giver or any other person or entity which may possess this information. This exclusion extends to any medical doctor, doctor of osteopathy, physician health care professional, hospital, clinic, medical facility, the Veterans Administration, employer, consumer, reporting agencies, other insurance companies, or anyone else with respect to previous test results. The applicant is not authorizing the Company to forward the results from any new test, requested of the applicant by the Company to an outside, non-affiliated company, nor to any entity not under specific contract with the Company to perform underwriting services.

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 Life Insurance Company, P.O. Box 4048, Woburn, MA 01888. I understand that any information that is disclosed prior pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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 understand that if I refuse to sign this Authorization to release my complete medical information, the Company may not be able to process my Application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

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

_____

Name of Proposed Insured

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

L. FRAUD WARNINGS

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or Producer of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information, is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and maybe subject to fines and confinement in prison.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person, who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio and Oregon: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer and/or insurance company, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance company containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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.

_____ Name of Proposed Insured

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

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:

SBLI® THE NO NONSENSE LIFE INSURANCE COMPANY®

The Savings Bank 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: _____

_____f_____

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

SBLI® | THE NO NONSENSE LIFE INSURANCE COMPANY®

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

California Secondary Addressee Designation Request

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

Under California law 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 Secondary Addressee Notice of Lapse will be in addition to the notice of lapse that we send to you.

Secondary Addressee Designation			
Designee's Name:			Day Phone:
Street Address:	City:	Zip Code:	Email:

I hereby request, pursuant to CA insurance code section 10113.72, that the above named person be notified of any policy lapse as described above.

.

_____ Print Name of Owner

_____ Signature of Owner

_____ Date Signed

SBLI® THE NO NONSENSE LIFE INSURANCE COMPANY®

CONDITIONAL RECEIPT AGREEMENT

The Savings Bank Life Insurance Company of Massachusetts
[P.O. Box 4048, Woburn, MA 01888]
Telephone [(800) 694-7254 www.sbli.com]
(Referred to herein 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 of this Agreement are met. If any conditions 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 10 years had unintentional weight loss; or any symptoms of a disease or an impairment for which he/she has not consulted a physician or a member of the medical profession? □ Yes □ No
   b. in the past 5 years had, been treated for, been advised to be treated for, or now has, 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 to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed? □ Yes □ No
   d. been diagnosed 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
3. Is the initial amount of life insurance coverage applied for on all applications pending with us, including the current amount of all existing life insurance coverage with us, greater than $1,000,000?	□ Yes □ No

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

1. All of the questions above are answered "NO"; and
2. An amount equal to the modal premium indicated on the application must be received by us; the mode must be either annual, semi-annual, quarterly or monthly (two months' premium required); and
3. All medical examinations, tests, x-rays and electrocardiograms initially required by our published rules with regard to age and amount requested for the risk class and plan applied for must be completed within ninety (90) days from the date this Agreement is signed; and
4. The Proposed Insured is, on the Effective Date, a risk acceptable for insurance exactly as applied for, or better, according to our rules and practices, without modification of plan, premium rate or amount; and
5. On the Effective Date the state of health and all factors affecting the insurability of the Proposed Insured for coverage must be as stated in all application documents required by us; and;
6. Any check, authorized withdrawal, credit card payment or any form of payment must be received and honored when first presented.

D. EFFECTIVE DATE

If all of the conditions above are met, then insurance coverage, subject to all the terms and conditions of the policy applied for and as if the policy applied for had already been issued and delivered, will become effective on the latest of: (a) the date of application; (b) the date of application – part II; (c) the date of completion of all underwriting requirements stated in Section (C)(3), above; or (d) the special policy date requested in the application, if any.

E. MAXIMUM AMOUNT

The maximum amount of life insurance coverage available under this Conditional Receipt Agreement shall be the lesser of: (1) the amount of insurance applied for in the application - part 1; or (2) $1,000,000, minus the amount of insurance on the Proposed Insured's life in force with us under any policies and Conditional Receipt Agreements, applied for or pending issue with us, including Accidental Death Benefits; 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 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 above are not met; or (2) A policy resulting from the application is refused; 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 application 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 above; (2) this limited amount of insurance will not begin unless all of the CONDITIONS listed above are first met exactly; (3) this Agreement will be void if the Agreement or application contains any material misrepresentation; 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 a policy 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 the application. I understand that my payment herewith has not purchased immediate life insurance coverage.

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 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® THE NO NONSENSE LIFE INSURANCE COMPANY®

The Savings Bank 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	

SBLI | THE NO NONSENSE LIFE INSURANCE COMPANY®

PRODUCER REPORT FORM

The Savings Bank 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)

SBLI® THE NO NONSENSE LIFE INSURANCE COMPANY®

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

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

Thank you for considering The Savings Bank 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 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 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 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 | THE NO NONSENSE LIFE INSURANCE COMPANY®

AUTOMATIC PAYMENT PLAN (APP) AUTHORIZATION

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

Our Company's Automatic Payment Plan (APP) is a convenient way to pay life insurance premiums. The Savings Bank Life Insurance Company of Massachusetts (referred to herein as "The Company", "We", "Us", or "Our") will collect the life insurance premiums from your bank account via an Electronic Funds Transfer (EFT) – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

- ▶ Complete, sign, date and return this form to Us with your application materials including a voided check.
- ▶ Please keep a copy of this form for your records.

APPLICATION INFORMATION

1. Proposed Insured Name (First, Middle, Last)

PREMIUM PAYMENT

For most products, payment frequency other than annual includes an additional cost. In those cases, the year's total premiums will be higher than if you paid one annual premium. The Company will withdraw the scheduled premium amount based on the payment frequency you have selected. If you choose the monthly payment frequency, you need to authorize two months of premium payment. This amount will be drafted only for the initial premium payment.

1. Payment frequency:	2. Payment Amount Authorized:
☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly	$

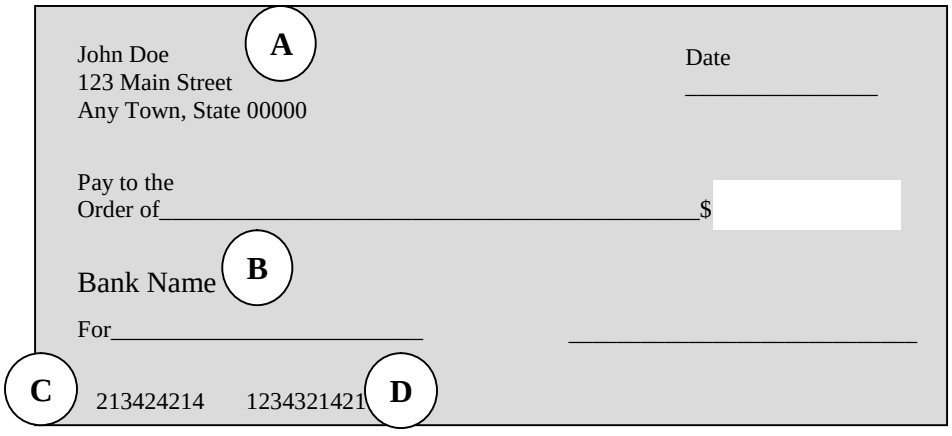
ACCOUNT INFORMATION

1. Initial Payment made via EFT: ☐ Yes ☐ No
If you do not check the initial payment selection, you must submit another form of payment to cover the initial premium payment, and The Company will use this electronic funds transfer for subsequent premium payments only.

2. Account Owner Name *(if different from Proposed Insured – see "A" below)*	3. Account Owner Street Address *(see "A" below)*
4. Account Owner City, State, ZIP *(see "A" below)*	5. Financial Institution Name *(see "B" below)*
6. Bank Routing Number *(see "C" below)*	7. Account Number *(see "D" below)* Type of Account: ☐ Checking ☐ Savings

Below is an example of a personal check. A business check may be different. The circled letters show you where to find the information required to process your electronic funds transfer.

PLEASE ATTACH YOUR CHECK HERE →



ACKNOWLEDGEMENT

By signing below, I (the Policyowner) understand and accept these terms and conditions (if applicable):

- Signing the Automatic Payment Plan Authorization does not mean that insurance is effective. The insurance is effective only as stated in the Application for Life Insurance or in the Conditional Receipt Agreement (CRA) if one is properly issued in connection with the application.
- This authorization will not affect the terms of the policy, other than mode of payment, and that if premiums are not paid within the applicable grace period, the policy will terminate, subject to any applicable non forfeiture provision.
- The Company will not provide coverage if the financial institution does not honor the withdrawal, even if The Company receives all other requirements.
- The debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until The Company receives actual payment.
- I agree to indemnify and hold The Company harmless from any loss, claim, or liability of any kind of reason for dishonor of any debit.
- The Company will initiate payment of the first premium only after it issues the policy. For monthly payments the initial draft includes at least the first two months of premium.
- The Company may issue the policy at a premium rate different from the rate for which I applied. In that case, The Company will give me advance notice of the new premium amount before The Company withdraws premiums. After the first withdrawal, The Company will withdraw premiums on the day of the month that corresponds to the policy issue date. (Refer to your policy to determine the policy issue date.)
- Coverage is effective under the CRA only if the initial premium amount withdrawn is sufficient to cover the required premium payment. (A minimum of two premium payments must be withdrawn if the premium payment frequency is monthly).
- If coverage ends as described in the CRA, The Company will issue a refund for any over payments

Additional Terms of this Agreement - A rejection of a debt entry because of insufficient funds in the account to pay the premium then due in full, plus any loan interest* on the premium due date will result in the termination of this agreement without the requirement of a notification to Policyowner or Accountholder. The Policyowner will be required to pay the amounts then due and all future premiums in cash**.** Upon such termination and provided that payments have not stopped for any reason, premiums will then be due on the most frequent basis allowed under The Policy. The Policyowner may choose any frequency allowed, but payments once a month will not be allowed. A partial premium may be due for the time from the then current paid-to-date to the start of the next regular premium period. We will initiate a debit entry 3 times before such termination is enacted. Once a payment is drawn from your account we cannot stop the draft or return the funds to your account. If the requested date of the draft falls on a weekend or holiday, payment will be drawn on the preceding business day. We will require notification from the Policyowner not less than 10 days prior to the draft date when requesting the stop of a draft occurring.

* Loan Interest
Unless otherwise requested, any loan interest due will be drafted annually from your account. To request to be billed directly for any loan Interest, please indicate so by checking the box below.

☐ I hereby request to have any loan interest due annually billed to me directly and not drafted from my account. I understand by electing this option, I am responsible for loan interest which is billed to me.

AUTHORIZATION

By signing below, I (the bank account owner) understand and accept these terms and conditions:

- The Company is authorized to withdraw funds periodically from my account to pay my insurance premiums, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such policy.
- If my financial institution does not honor a withdrawal request, The Company will NOT consider my premium paid.
- This Authorization may be terminated immediately by The Company if any debit is not honored by the financial institution named for any reason, otherwise upon 30 days of written notice to the Policyowner.
- If you want to cancel or change this authorization, you must contact The Company at least ten business days before a scheduled withdrawal.

SIGNATURES

_____ _____

Signature of premium payor (bank account owner) Date:

_ _____ _____

Signature of Policyowner (If different from premium payor) Date:

SBLI® | THE NO NONSENSE LIFE INSURANCE COMPANY®

The Savings Bank Life Insurance Company of Massachusetts
One Linscott Road, Woburn MA 01801
Telephone (800) 694-7254

NOTICE REGARDING REPLACEMENT:

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Insurer Name	Contract or Policy No.	Insured or Annuitant

Applicant's Certification

I certify that the responses in this document are, to the best of my knowledge, accurate. I recognize that, for a period of 30 days from the date I receive my new policy or contract, I have the right to return it for an unconditional full refund of all premiums or considerations paid on it, including any policy fees or surrender charges. If this transaction is a replacement of a SBLI policy, I understand that credit will be allowed for the period of time that has elapsed under the replaced policy's incontestability or suicide period up to the face amount of the replaced policy.

Applicant's Signature	Applicant's Printed Name	Date

Agent's Signature	Agent's Printed Name	Date