

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**

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- ▶ 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**

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- ▶ 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

INDIVIDUAL  
LIFE INSURANCE  
APPLICATION

Part 1

In this application, "You" and "Your" refer to the Proposed Insured. "SBLI" refers to The Savings Bank Mutual Life Insurance Company of Mass

**A. PRODUCT INFORMATION**

Product: 1. <input type="checkbox"/> Term: <input type="checkbox"/> 10Yr LT <input type="checkbox"/> 15Yr LT <input type="checkbox"/> 20Yr LT <input type="checkbox"/> 25Yr LT <input type="checkbox"/> 30Yr LT <input type="checkbox"/> YRT <input type="checkbox"/> Whole Life: <input type="checkbox"/> SL <input type="checkbox"/> L10 <input type="checkbox"/> L15 <input type="checkbox"/> L20 <input type="checkbox"/> L@65 <input type="checkbox"/> SPL <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	2. Base Insurance Amount:	3. Site of Sale (city, state)
4. Riders/Additional Benefits: <input type="checkbox"/> Single Pay Paid-Up Additions: \$ _____ <input type="checkbox"/> Term Rider: Plan _____ Amount: \$ _____ <input type="checkbox"/> Child Rider: \$ _____ <input type="checkbox"/> Flex Pay Paid-Up Adds: Scheduled Premium: \$ _____ <input type="checkbox"/> GPO: \$ _____ <input type="checkbox"/> Accidental Death: \$ _____ <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accelerated Death Benefit <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____		

**B. PROPOSED INSURED INFORMATION**

1. Full Name (First, M.I., Last):	2. Sex: <input type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth:	4. Birth State & Country	5. Soc. Sec. No.:
6. Home Address (Number, Street, City, State, Zip Code):		7. Phone and E-mail: Home #: _____ Cell#: _____ Work#: _____ E-mail: _____ Preferred mode of contact: _____		
8. Driver's License #: _____ State where issued: _____	9. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed # of dependents: _____ Ages: _____		10. U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "No", complete a Citizenship Questionnaire and attach copy of green card or visa)</i>	
11. Occupation (include duties):	12. Employer Name and Address:		13. How long employed?	
14. Have you ever used tobacco; any other nicotine product; or nicotine by-product of any type? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes"; Type: _____ How long used: _____ Last used: (mm/yy) _____ Amount & How often: _____				
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", how much? \$ _____				

**C. OWNER OF INSURANCE APPLIED FOR (Complete only if Owner is to be other than the Insured.) ANSWER #1a OR #1b**

1a. Type: <input type="checkbox"/> Individual If you check this box complete items 2 through 11 only and proceed to Section D.		1b. Type: <input type="checkbox"/> Trust <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other (Specify): _____ If you check any of the above, proceed to item 12 below.		
2. Owner Name	3. Date of Birth (mm/dd/yy)	4. Relationship to insured		
5. Home Address (#, Street, City, State, Zip Code)	6. E-mail	7. Soc. Sec./Tax I.D. #		
8. Billing Address, if different (#, Street, City, State, Zip)	9. Home Phone #: _____ Work Phone #: _____	10. Driver's License #: _____ State Issued: _____		
11. U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "No", complete the Citizenship Questionnaire and attach a copy of Green card or visa)</i>				
<b>Complete questions 12 through 22 only if 1b above is completed. Otherwise proceed to Section D.</b>				
12. Name of Non-Natural Owner (Trust, Corporation, etc.)		13. Tax I.D. # (TIN).		
14. Name of Corporate Officer, if applicable	15. State where Incorporated	16. Phone Number(s): _____ E-mail: _____		
17. Billing Address (#, Street, City, State, Zip Code)				

_____ Name of Proposed Insured
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**Complete questions 18 through 22 only if the Owner is a Trust. Otherwise proceed to Section D.**

18. Purpose of Trust	19. Date of Trust (mm/dd/yy)	20. Type of Trust <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
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21. Trust Contact Name, Address, Telephone #

22. Does the above Trustee have sole authority to act on behalf of the Trust?  Yes  No  
*(If "No", list all Trustees below and obtain their signatures. Attach a separate page, if more space is needed.)*

Name of Trustee	Address	Signature

**D. BENEFICIARY** *If percentages are not shown, shares will be distributed equally. Total % of primary shares must equal 100%. Total % of contingent shares must equal 100%. Attach a separate sheet if more space is needed.*

**1. Primary Beneficiaries**

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

**2. Contingent Beneficiaries (Only in event that no Primary Beneficiary survives the Insured)**

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

**3. If the beneficiary is a Trust or Corporation, is it the same as the above Owner?**  Yes  No *If "No", provide the following:*

Name of Trust or Corporation	State where Incorporated	Date of Trust	List Trustees. Attach a separate page, if more space is needed.
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**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? <input type="checkbox"/> Yes (Date of Discharge: _____) <input type="checkbox"/> No
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\_\_\_\_\_  
Name of Proposed Insured

<b>Business Section</b>	
6. Purpose of Insurance: <input type="checkbox"/> Buy-Sell <input type="checkbox"/> Key Employee <input type="checkbox"/> Secure Credit <input type="checkbox"/> Other (Specify):	7. Is the business a: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> 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? <input type="checkbox"/> Yes (Date of Discharge) <input type="checkbox"/> No	
13. Net Profit after taxes for the past two years: Last Year: \$ Prior 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 that is in force on other key members of the business.  
 b. If applicable, describe why there is no insurance applied for or in force on other key members of the business.

**F. PROPOSED INSURED PERSONAL HISTORY**

1. Have you ever: (a) sold a life insurance policy; or (b) have you entered, or made plans to enter, an agreement to sell the policy being applied for; or (c) has any person promised, agreed to give, or given to any party to the application any inducement, fee or compensation to purchase the policy? (If "Yes", provide details below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have any other applications or informal inquiries for life insurance pending with any other company, society or association? (If "Yes", provide details below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever had an application or reinstatement request for life or disability insurance: refused or limited; or have you been asked to pay a higher premium? (If "Yes", provide details below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, in the last 2 years, resided or traveled, or do you intend to reside or travel, outside of the United States within the next 2 years? (If "Yes", complete the Foreign Travel Questionnaire).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the last 3 years, has your driver's license been suspended or revoked; or have you plead guilty to, or been convicted of, any moving violations? (If "Yes", provide details below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
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).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Except for traffic violations, have you plead guilty or been convicted of, a misdemeanor or felony, or do you have a felony charge pending against you? (If "Yes", provide details below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever engaged in or, within the next 2 years do you intend to engage in, flying a plane, racing motor boats or motor vehicles, or to participate in sky-diving or parachuting, hang-gliding, hot air ballooning, mountain, rock or ice climbing, or scuba diving? (If "Yes", complete the appropriate Hazardous Activities and/or Aviation Questionnaire).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Are you currently, or have you entered into a written agreement to become, a member of the Armed Forces (including the Reserves or National Guard)? (If "Yes", complete the Military Questionnaire).....	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Question #	Details

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

1. Initial Payment Method: <input type="checkbox"/> Check <input type="checkbox"/> COD <input type="checkbox"/> Credit Card <input type="checkbox"/> Electronic Fund Transfer (EFT) <input type="checkbox"/> Other (Specify):	2. Payment Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (EFT only)	3. Send Premium Notices to: <input type="checkbox"/> Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (Specify):
4. Amount paid with Conditional Receipt Agreement (CRA): \$	5. Would you like to back-date your policy to save age? (If "Yes", see Back-dating Disclosure section in the Notice to Proposed Insured and Owner)..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Identify the person or entity that is paying the first premium for the insurance applied for: <input type="checkbox"/> Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other – provide details; include payor name, address, relation to insured, tel. # and Tax I.D./Social Security #		

*The Automatic Premium Loan Provision to be effective, if available, unless requested otherwise here:*  Not Effective

\_\_\_\_\_  
Name of Proposed Insured

**H. DIVIDEND OPTION** (If none is 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  
 3.  Purchase Paid Up Life Additions                      4.  Accumulate at interest                      (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 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 it 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 with SBLI or any other company? (If "Yes", provide details below. Complete state required replacement form for New NAIC Model Replacement Regulation States only)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you intend to replace any existing life insurance or annuity contract with the insurance applied for? (If "Yes", complete state required replacement form and provide details below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you stopped making premium payments, surrendered, forfeited, assigned to SBLI, 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Insurance Companies (Do not include group policies)	Name of Insured	To be replaced?	Contract / Policy #	Cash Value / Amount of Coverage	Date of Issue
		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	

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

**K. 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.

**L. 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 SBLI's rights or requirements; or (d) waive any information SBLI 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 SBLI, 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

**M. 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 SBLI 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 SBLI.
- 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 cannot 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.

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 Mutual Life Insurance Company, P.O. Box 4048, Woburn, MA 01888.

This Authorization shall remain in force for 24 months or the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, 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

**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 SBLI 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), if issued, 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 SBLI, 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  
 - SBLI'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 <b>X</b> _____	Date	Signature of Owner/Applicant (if not Proposed Insured) <b>X</b> _____	Date
Signature of Producer <b>X</b> _____	Date	Signature of Producer <b>X</b> _____	Date
Signed at (City and state)	Producer #	Signed at (City and state)	Producer #
Producer Name Printed		Producer Name Printed	
Rate applied for:			

SBLI 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**

- Does the Applicant have existing life insurance policies or annuity contracts?  Yes (Submit the state applicable replacement form)  No
- 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
- 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
- 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
- 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
- Have you received relevant anti-money laundering training within the last 24 months that was offered by SBLI, another life insurance company or a competent third party (e.g., LIMRA)?  Yes  No
- Do you acknowledge that you are in compliance with your requirements as stated in SBLI'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 #: Source: Rate Code: Process Date:	Underwriting Stamp
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**The Savings Bank Mutual Life Insurance Company of Massachusetts**  
P.O. Box 4048, Woburn, MA 01888  
Telephone (800) 694-7254 [www.sbli.com](http://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 may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, 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](http://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.

## 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. If you have questions concerning AIDS/HIV you may wish to contact the National Institute of Health's AIDS info at 1-800-HIV-0440 or the Center for Disease Control at 1-800-CDC-INFO.

**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. In addition to utilizing the services provided by the National Institute of Health or the Center for Disease Control, your private physician, a public health clinic, or an AIDS information organization in your state may also 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, state law requires the insurer to only release the test results to 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:**

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**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.

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Print Name of Proposed Insured	Signature of Proposed Insured or Parent/Guardian	Date
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Address:

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



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")

Box for 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?
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?
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)?
d. been diagnosed by a medical professional as having Hepatitis C, Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?
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?

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.

<hr/> Name of Proposed Insured
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**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
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**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
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**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.**

## 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 (SBLI)**  
[One Linscott Road, Woburn, MA 01801 800-694-7254]

**Application Amendment**

**- AGENT CERTIFICATION -**

<b>Proposed Insured:</b>		<b>Application Date:</b>		<b>Reference Number:</b>	
<b>Amount Applied for:</b>	<b>Type Applied for:</b>	<b>Agency Name:</b>		<b>Agency Number:</b>	

Does the sale of this insurance involve a replacement of an existing life insurance policy or annuity (other than SBLI)?

- No     Yes – (submit Replacement form A-52)

I hereby certify that I have completed the application on the proposed insured name above.

**Please Sign Here:**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent's Name & Number (please print)

X \_\_\_\_\_  
Signature of Agent



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

**IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

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

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

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

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the life insurance policy values, including accumulated dividends, of an existing life insurance policy to pay all or part of any premium or payment due on the new life insurance policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your life insurance policy or contract. You may be able to make changes to your existing life insurance policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing life insurance policy and may reduce the amount paid upon the death of the insured.

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

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or contract? .....  Yes  No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new life insurance policy or contract? .....  Yes  No

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

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			
4.			

Make sure you know the facts. Contact your existing company or its agent for information about the old life insurance policy or contract. If you request one, an in-force illustration, life insurance policy summary, or available disclosure document must be sent to you by the existing insurer. Ask for and keep all sales material used by the insurance producer in the sales presentation. Be sure you make an informed decision.

The existing life insurance policy or annuity contract is being replaced because:

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

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

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

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

**PREMIUMS:** Are they affordable?  
Could they change?

You're older-- are premiums higher for the proposed new life insurance policy?  
How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:** New policies usually take longer to build cash values and to pay dividends.  
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.  
What surrender charges do the policies have?  
What expense and sales charges will you pay on the new policy?  
Does the new policy provide more insurance coverage?

**INSURABILITY:** If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.  
You may need a medical exam for a new policy.  
Claims on most new policies for up to the first 2 years can be denied based on inaccurate statements.  
Suicide limitations may begin anew on the new coverage.

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**  
How are premiums for both policies being paid?  
How will the premiums on your existing policy be affected?  
Will a loan be deducted from death benefits?  
What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**  
Will you pay surrender charges on your old contract?  
What are the interest rate guarantees for the new contract?  
Have you compared the contract charges or other life insurance policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**  
What are the tax consequences of buying the new policy?  
Is this a tax-free exchange? (See your tax advisor.)  
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?  
Will the existing insurer be willing to modify the old policy?  
How does the quality and financial stability of the new company compare with your existing company?

**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 policy.**



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

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 ft.          in.	b. Weight lbs.	c. Have you had any weight changes in excess of 10lbs. in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Pounds Lost _____ Pounds Gained _____ Reason _____	
d. Have you had any surgical treatment for weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Date of Surgery ____ / ____ / ____ Describe _____			
5. Do you have a personal Physician or health care provider? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Please provide the name of your Physician or health care provider you last consulted, if different from the above. <i>If more than one, provide name(s) in DETAILS section.</i>			
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Depression, anxiety, attention deficit/hyperactivity, suicidal thoughts or attempts, anorexia or bulimia, or any other psychological, psychiatric, emotional, or mental disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Colitis, Crohn's disease, hepatitis, cirrhosis, or any other disease or disorder of the liver, pancreas, gallbladder, esophagus, stomach, or intestines?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Disorder of kidney, bladder, prostate, blood or protein in the urine, or any disease or disorder of the genitourinary system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Disorder of breast or reproductive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Arthritis or any other disease or disorder of the muscles, bones, spine, or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Anemia, coagulation or clotting disorder, or any other disease or disorder of the blood or lymph nodes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Lupus, autoimmune disease or disorder, or connective tissue disease?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
4. During the past 5 years, have you:				
a. Had an electrocardiogram, x-ray, blood test, or other diagnostic test excluding HIV test?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
b. Requested or received disability or compensation benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5. Have you ever been diagnosed by a licensed member of the medical profession or tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
b. Please complete the following:				
	Age if Living	Age at Diagnosis	Age at Death	Cause of Death
Father				
Mother				
<input type="checkbox"/> Brother <input type="checkbox"/> Sister				
<input type="checkbox"/> Brother <input type="checkbox"/> Sister				
<input type="checkbox"/> Brother <input type="checkbox"/> Sister				
<input type="checkbox"/> Brother <input type="checkbox"/> Sister				
<input type="checkbox"/> Brother <input type="checkbox"/> Sister				
<input type="checkbox"/> Brother <input type="checkbox"/> 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.

<hr style="width: 80%; margin: 0 auto;"/> Name of Proposed Insured
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**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  X _____	Date	City, State
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**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  X _____	Countersigned (Licensed resident Producer if state required)  X _____	

If Tele-interviewer recorded information:

Name	Date
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If Paramedical recorded information:

Examiner's Name	Date	Phone Number
Signature of Examiner  X _____	Date	City, State

<hr/> Name of Proposed Insured
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<b>F. CUSTOMER IDENTITY INFORMATION :</b> 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 (SBLI)**

One Linscott Road, Woburn, MA 01801 800-694-7254

**Application Amendment**

**- General Questionnaire -**

*Please Read Carefully, Answer All Questions and Sign Below*

<b>Proposed Insured:</b>	<b>Application Dated:</b>	<b>Policy Number:</b>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The following questions relate to the person proposed for insurance and his/her history of \_\_\_\_\_

1. Please provide the complete names and addresses of the doctor and/or hospitals that have treated you for this condition.
2. Please advise the number of occurrences of this condition you have had, and the dates.
2. Have you ever been hospitalized for this condition?  No  Yes If "Yes", provide details:
3. What medications, if any, have been prescribed?

Are you on medication at present?  No  Yes If "Yes", provide details:

4. Have you ever had treatment other than medication?  No  Yes If "Yes", provide details:

To the best of my (our) knowledge and belief, I (we) hereby agree that all representations made above are true and complete to the best of my (our) knowledge and belief as of the date signed below. I agree that SBLI, believing them to be complete 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.

**Please Sign Here:**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Insured  
(If age 15 or over)

\_\_\_\_\_  
Signature of Applicant/Owner, if other  
than the Proposed Insured

\_\_\_\_\_  
Name of Proposed Insured (Print)

\_\_\_\_\_  
Name of Applicant/Owner (Print)

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

**A. PROPOSED INSURED**

1. Full Name (First, Middle, Last)	2. Date of Birth (mm/dd/yyyy)	3. SBLI Reference #
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**B. APPLICATION UPDATE**

Since the later of the date of the application for life insurance or the insurance exam:

- 1. Has the Proposed Insured been treated by a member of the medical profession? .....  Yes  No
- 2. Has the Proposed Insured:
  - Been diagnosed by a member of the medical profession of any illness or has been an inpatient or outpatient in a hospital?** .....  Yes  No
  - Consulted or been advised by a member of the medical profession to see a doctor for any reason? .....  Yes  No
  - | Been advised by a member of the medical profession to have an operation or diagnostic test that has not been completed? .....  Yes  No
  - Had life, accident or health insurance:
    - Postponed or declined? .....  Yes  No
    - Cancelled? .....  Yes  No
    - Renewal or reinstatement refused? .....  Yes  No
    - Rated with an extra premium? .....  Yes  No

Details of any "Yes" answers:

**C. REPRESENTATION AND SIGNATURE(S)**

**REPRESENTATION:**

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 The Savings Bank Mutual Life Insurance Company of Massachusetts ("SBLI"), believing them to be complete, correct, and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

**SIGNATURE(S)**

Proposed Insured	Date	Owner/Applicant (if not Proposed Insured)	Date
Producer	Date	Producer	Date

The Savings Bank Mutual Life Insurance Company of Massachusetts  
P.O. Box 4047, 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 Mutual 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:

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** →

John Doe A      Date \_\_\_\_\_  
 123 Main Street  
 Any Town, State 00000

Pay to the Order of \_\_\_\_\_ \$ \_\_\_\_\_

Bank Name B  
 For \_\_\_\_\_

C 213424214    1234321421 D

**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:

**AUTHORIZATION FOR PAYMENT OF  
INITIAL PREMIUM BY CREDIT CARD**

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

- ▶ Complete, sign, date and return this form to The Savings Bank Mutual Life Insurance Company of Massachusetts, (referred to herein as "The Company", "We", "Us" or "Our") with your application materials.
- ▶ The amount of the Initial Premium will be determined based upon the payment method you selected on your application.

**APPLICATION INFORMATION**

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

**CREDIT / DEBIT CARD (VISA OR MASTERCARD ONLY)**

1. Type of Credit Card:  <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	2. Name of Card Holder as shown on the Card:	3. Expiration Date: (MM/YY)
4. Card Number: <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	5. Billing Address of Card Holder ( <i>Street, City, State, Zip Code</i> ):	

**AUTHORIZATION**

I authorize The Company to collect the Initial Premium by the Payment Method I have selected. I understand and agree that this Authorization is subject to the following conditions:

- Signing this Authorization does not mean that insurance is effective. Insurance is effective only as stated in (1) the application for insurance; or (2) the Conditional Receipt Agreement (CRA) if one is properly issued in connection with the application.
- This authorization does not modify any terms or conditions of the policy.
- This transaction is subject to the acceptance by, and the terms and conditions of, the credit card company indicated above.
- The Company will initiate payment of the Initial Premium upon issuance of the policy subject to the terms and conditions of any applicable CRA and or delivery requirements.
- If a policy is issued, it may be issued at a premium rate different from the rate for which you applied. If this situation occurs, The Company will adjust the payment amount to reflect the appropriate modal premium charge.
- If the Payment Method selected is not honored for any reason upon presentation, this Authorization will not be effective as a premium payment; no insurance will be effective, and The Company will make no further attempts to use this Authorization to obtain payment of premium.
- This Authorization may be revoked by me upon written notice at any time prior to its use by The Company to obtain payment of the Initial Premium.
- I understand and agree that The Company shall incur no liability if the credit card company dishonors any amount charged under this Authorization and may terminate this Authorization immediately if any charges are not paid.
- I agree to hold The Company harmless against any liability pursuant to this Authorization.
- This Authorization pertains to payment of the Initial Premium only. No further premiums will be collected under this Authorization.
- Any refund of premium will be credited to my account.

**SIGNATURE**

_____ Signature of Card Holder	_____ Date
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## 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<sup>1</sup> (“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](mailto: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](mailto: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

<sup>1</sup> 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.