

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

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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 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.

**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 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 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.

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

**A. PRODUCT INFORMATION**

1. Product <input type="checkbox"/> Level Term: <input type="checkbox"/> 10Yr <input type="checkbox"/> 15Yr <input type="checkbox"/> 20Yr <input type="checkbox"/> 25Yr <input type="checkbox"/> 30Yr <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"/> YRT <input type="checkbox"/> Other _____	2. Face Amount	3. Riders/Additional Benefits <input type="checkbox"/> Term Insurance Rider Plan _____ \$ _____ <input type="checkbox"/> Child Insurance Rider \$ _____ <input type="checkbox"/> Waiver of Premium Rider <input type="checkbox"/> Other: _____	4. Location of Sale (city, state)
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**B. PROPOSED INSURED INFORMATION**

1. Full Name (First, Middle, Last. Include maiden name)	2. Sex <input type="checkbox"/> M <input type="checkbox"/> 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: <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 (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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> 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 <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	14. Name of Trustee(s)/Corporate Officer		
15. Does the above Trustee have sole authority to act on behalf of the Trust? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes (Date of Discharge: _____) <input type="checkbox"/> No
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**Business Section**

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: \$ 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**

- 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
- 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
- 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
- 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
- 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

\_\_\_\_\_  
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.

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
- the Medical Information Bureau (MIB)

This protected health 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, the MIB, Inc., 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** \_\_\_\_\_

\*If the insured is under the age of 18, signature of  Parent  Guardian  Other: \_\_\_\_\_

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

#### 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**

- 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 the company, 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 the company's Producer's Guide to Anti-Money Laundering (AML) and are unaware of any AML Red Flags as described in your AML training?  Yes  No

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

X \_\_\_\_\_ (Producer's Signature) \_\_\_\_\_ (Producer's Printed Name) \_\_\_\_\_ (Date)

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

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

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		

# Application Supplement

## The Savings Bank Life Insurance Company of Massachusetts

To be completed with all applications in excess of \$1,000,000 (applied for plus in force)

Name of Insured (Please Print)	Application Number	Application Dated
--------------------------------	--------------------	-------------------

### A. Other Life Insurance:

1. How much insurance is currently in force on the life of the proposed Insured?

	<u>Personal</u>	<u>Business</u>	<u>Describe the purpose of the business insurance</u>
Life	\$ _____	\$ _____	_____
Accidental Death	\$ _____	\$ _____	_____
Approximate premium	\$ _____	\$ _____	_____

2. Did you, within the last ninety days, or do you intend to, within the next 90 days, apply to other companies for life insurance coverage?  No  Yes If "Yes", Complete the following:

<u>Company applied to</u>	<u>Amount of Insurance</u>	<u>Purpose of Insurance</u>
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

3. Will any insurance listed in #2 above be purchased in addition to the SBLI coverage applied for?

No  Yes If "Yes", provide details: \_\_\_\_\_  
\_\_\_\_\_

### B. Personal Annual EARNED Income statement:

The information provided is for calendar year ended December (insert year): \_\_\_\_\_  
and is (check one):  Actual  Estimated

1. Income from Employment by others:

Salary \$ \_\_\_\_\_ + Bonuses \$ \_\_\_\_\_ + Commissions \$ \_\_\_\_\_ + Other\* \$ \_\_\_\_\_ = Total \$ \_\_\_\_\_  
\*Describe "Other": \_\_\_\_\_

2. Income from Self Employment:

Gross Income \$ \_\_\_\_\_ - Business expenses \$ \_\_\_\_\_ = Adjusted Gross Income \$ \_\_\_\_\_  
+ Other\* Income \$ \_\_\_\_\_ = Total Net Earnings \$ \_\_\_\_\_  
\*Describe "Other": \_\_\_\_\_

3. Spouse's Earned Income: \$ \_\_\_\_\_

### C. Other Income:

Total other income (dividends, interest, etc.) for the calendar year: \$ \_\_\_\_\_

### D. Financial History:

1. Have you filed for any bankruptcies in the past 14 years, or are you contemplating bankruptcy?

No  Yes If "Yes", provide details (voluntary or involuntary, whether all obligations have been satisfied and discharged, and date(s) discharged, etc.):  
\_\_\_\_\_

2. Are there any suits or judgements pending against you at this time?

No  Yes If "Yes", provide details: \_\_\_\_\_  
\_\_\_\_\_

### E. Net Worth:

1. Assets (Value of Savings, Stocks, Real Estate, Personal Property, etc.) \$ \_\_\_\_\_  
2. Liabilities (Value of Mortgages, Other Loans, Other Debt, etc.) - \_\_\_\_\_  
3. Net Worth (Item 1 minus Item 2) = \_\_\_\_\_

- Continued on Reverse Side -

**F. Purpose of Coverage:**

Personal (If personal, check all that apply)  Family Protection  Estate Conservation  Other\*

\*Describe "Other": \_\_\_\_\_

Business (If business, check all that apply)

Key Man (are any other Key Men similarly insured?  Yes  No (Explain below)

Buy-Sell (are other co-owners similarly insured?  Yes  No (Explain Below)

Creditor - Please enter amount of loan: \$ \_\_\_\_\_

Name and address of lender: \_\_\_\_\_

Does lender require life insurance?  Yes  No (Explain Below)

Other: (Explain Below)

Explanation of "No" and "Other" answers: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**G. Business Insurance Applicants only:**

(If "Personal" only is checked in section F above, skip this section and go to signature area below)

1. Type of Business:  Sole Proprietorship  
 Partnership  
 Corporation (State of incorporation: \_\_\_\_\_ )

2. Complete the following for each Partner, Owner, or Corporate Officer or Key Person:

Name	Position/Title	% of Ownership	Amount of Insurance Payable to Business	
			In Force	Applied for
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. If no business associates (listed in # 2 above), other than the proposed Insured named at the top of this form are to be insured, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**H. Business Finances (Attach a copy of profits & loss statement and balance sheets for last 3 years, if available)**

Year	Assets	Liabilities	Net Worth	Gross Sales	Net Profits
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is there a Written Buy/Sell Agreement?  No  Yes (Submit a copy)

Has business ever been reorganized because of financial difficulties?  No  Yes (Explain)

**I. Signature:**

The above financial disclosures are made for the purpose of establishing insurability in connection with an application for life insurance submitted to The Savings Bank Life Insurance Company of Massachusetts on my life. They are furnished as a true and accurate statement of my financial condition as of this date.

Date: \_\_\_\_\_ Signature of Proposed Insured: \_\_\_\_\_

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. SSN/TIN	3. Producer Company #
4. Phone #: Fax #: Email:	5. 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	SSN or TIN	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)

## NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions (for example, the decision to accept or reject your application) will be based on the test results. You may have ten (10) days to decide whether you wish to sign this form. You may refuse to be tested. However, such refusal may be used by the insurer as a reason to deny coverage. Please see below for additional counseling information.

### INFORMATION ON HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen and vaginal fluids. The disease is spread primarily during anal, vaginal or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. *HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.*

Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

### PRE-TEST COUNSELING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV antibody/antigen test a person seek counseling to become fully informed about the implications of such tests. You may wish to consider obtaining such counseling at your own expense prior to being tested. Free confidential counseling is available in most Arizona communities. If you need information about the availability of counseling in your area contact your county health department or:

**Phoenix Metropolitan Area: 253-2437**  
**(Arizona AIDS Information Line)**  
**Outside the Phoenix Area: 1-800-334-1540**  
**(Arizona Department of Health Services)**

### DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not be otherwise disclosed without your written consent except as required by law. Disclosure of HIV test results pertaining to your application for insurance is governed by A.R.S. § 20-448.01.

### MEANING OF POSITIVE TEST RESULTS

The most commonly used test is designed to detect the presence of antibodies to the virus. Antibodies are made by the body's immune system to fight infection. While positive HIV antibody test results do not mean that you have AIDS, they do indicate that you have been infected with HIV, the virus that causes AIDS.

Positive HIV antibody/antigen test results will adversely affect your application for insurance. This means that your application will probably be declined.

### CONSENT

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have a right to request and receive a copy of this form. A photocopy of this form will be as valid as the original. I understand that the provisions of this consent form shall be effective for a period not to exceed 180 days from the date this form was signed by me or my legal representative.

\_\_\_\_\_  
(Print Name of Proposed Insured or Parent/Guardian)

\_\_\_\_\_  
(Signature of Proposed Insured or Parent/Guardian)

\_\_\_\_\_  
(Date)

### OPTIONAL RELEASE OF INFORMATION TO PERSONAL PHYSICIAN

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below:

\_\_\_\_\_  
**Physician's Name (Printed)**

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(Zip Code)

\_\_\_\_\_  
(Print Name of Proposed Insured or Parent/Guardian)

\_\_\_\_\_  
(Signature of Proposed Insured or Parent/Guardian)

\_\_\_\_\_  
(Date)

**(Original - Home Office • Original – Proposed Insured)**

**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?

**Applicant's Certification:** 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 policy.

X \_\_\_\_\_  
Applicant's Signature Applicant's Printed Name Date

**Producer's Certification:** I certify that the responses in this document are, to the best of my knowledge, accurate and that this replacement transaction is in accord with the Company's replacement guidelines with respect to the acceptability and appropriateness of such transactions. In connection with a replacement transaction, I have left a copy of all sales material with the applicant. (Any electronically presented material will be provided to the applicant in printed form, no later than the policy or contract delivery.) I have enclosed copies of illustrations (If the product is illustrated), any disclosure documents and sales materials. I have identified and listed below any preprinted or electronically presented company approved sales materials that were used (If no sales materials were used, indicate "None").: \_\_\_\_\_

X \_\_\_\_\_  
Producer's Signature Producer's Printed Name Date

(Original - Home Office, 2nd Copy - Applicant, 3rd Copy - Producer)

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

The Savings Bank 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 Life Insurance Company of Massachusetts, (referred to herein as "The Company", "We", "Us" or "Our") with your application materials.
- ▶ Indicate the amount of the Initial Premium. It must equal the first modal premium or first two months of premium if paying monthly.

**APPLICATION INFORMATION**

1. Proposed Insured Name (First, Middle, Last):	2. Amount of Initial Premium:
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**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 (Street, City, State, Zip Code):
--	--

**AUTHORIZATION**

I authorize The Company to collect the Initial Premium stated above 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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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: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	2. Payment Amount Authorized: \$ _____
---	---

**ACCOUNT INFORMATION**

1. Initial Payment made via EFT: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Checking <input type="checkbox"/> 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 <b>A</b> 123 Main Street Any Town, State 00000	Date _____
Pay to the Order of _____ \$ _____	
Bank Name <b>B</b> For _____	
<b>C</b> 213424214    1234321421 <b>D</b>	

**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:

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
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**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**

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| 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?   | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> 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?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. been diagnosed as having Hepatitis C, Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  | <input type="checkbox"/> Yes <input type="checkbox"/> 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?   | <input type="checkbox"/> Yes <input type="checkbox"/> 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 \$500,000?   | <input type="checkbox"/> Yes <input type="checkbox"/> 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) \$500,000, 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.

<hr/> Name of Proposed Insured
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**G: AGREEMENT**

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
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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 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.
- The 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 Life Insurance Company of Massachusetts

## **NOTICE AND CONSENT FORM EMPLOYER-OWNED LIFE INSURANCE**

Name of Employer (hereinafter "the Company"): \_\_\_\_\_

Name of Employee/Director of Company: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Gender: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age Nearest Birthday (Cannot Exceed 65): \_\_\_\_\_  
(Month) (Day) (Year)

Home Address: \_\_\_\_\_  
(Street) (City or Town) (Zip Code)

Business Address: \_\_\_\_\_  
(Street) (City or Town) (Zip Code)

### **Check One of the Following:**

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

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

\_\_\_\_\_  
EMPLOYEE NAME

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE