CHILDREN'S RIDER QUESTIONNAIRE

SAVINGS BANK LIFE INSURANCE

Supplement to application for:

Amount applied for under this questionnaire for each child: $ _____

Name of Insured (Parent)	Agency No.	Agent No.	Application No.

Any child, stepchild or legally adopted child less than 17 1/2 years old must be listed below to be considered for insurance.

1. Full Name of each child proposed to be insured	2. Sex M or F	3. Amt. of existing Mass. SBLI (Include riders)	4. Date of Birth Month	Day	Year	5. Child's Height	Weight	6. Grade at school	(LEAVE BLANK)
(a)									
(b)									
(c)									
(d)									
(e)									
(f)									

If there are any children under age 17 1/2 not listed above, explain in "Details" below. Insurance will not begin for any child until the 15th day of life.

FOR QUESTIONS 7-11, IF ANSWERED "YES", GIVE DETAILS AT RIGHT.	YES	NO
7. Is any child named above blind or partially blind?	___	___
8. Is it contemplated that any child named above will reside or travel outside the United States and Canada except for vacations?	___	___
9. Has there been any case of tuberculosis, diabetes, cancer, heart disease, insanity, suicide, or mental impairment among the children's relatives? (This includes parents, brothers, sisters and grandparents.)	___	___
10. Has any child named above:		
a. had or been exposed to any infectious disease within the past month?	___	___
b. any discharge from ears or hearing impairment?	___	___
c. had any contact with any person who has or has had tuberculosis?	___	___
d. ever had an electrocardiogram, x-ray, or other diagnostic test?	___	___
e. ever had rheumatic fever, or any heart murmur?	___	___
f. ever had cancer or any other tumor?	___	___
g. any deformity, congenital disorder, or limitations of normal activities?	___	___
h. ever been diagnosed as having or been treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for antibodies to the AIDS virus?	___	___
i. any mental retardation or mental impairment?	___	___
j. ever had an application for life or health insurance declined, postponed, modified or offered at other than regular premiums for the child's age?	___	___
11. Has any doctor or practitioner (including dispensaries, hospitals, and other institutions) ever been consulted on behalf of any of the above named children for, or has any such child suffered from, any illness or disease of:		
a. the brain or nervous system?	___	___
b. the heart, blood vessels, or lungs?	___	___
c. the stomach or intestines?	___	___
d. skin, glands (including diabetes), middle ear, or eyes?	___	___
e. any other kind (other than uncomplicated measles, whooping cough, and chicken pox) not included above?	___	___
12. Are all the children named above now in good health to the best of your knowledge and belief? (If "No", give details at right.)	YES	NO
13. Changes made by SBLI	___	___

DETAILS OF ANSWERS

(Identify question number and give name of child. Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities, if applicable.)

_____ _____

Date Agent's Signature

I hereby certify that the statements above are correct and agree that SBLI, believing them to be correct, shall rely and act on them. I agree that this questionnaire shall become part of my application for insurance.

I further certify that I have read the ABBREVIATED NOTICE OF INFORMATION PRACTICES and read and signed the AUTHORIZATION which are contained on the reverse side of this form.

_____ _____ _____

DATE SIGNATURE OF APPLICANT RELATIONSHIP TO CHILDREN

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS

(Continued from reverse side)

Name of Insured (Parent)	Agency No.	Agent No.	Application No.

AUTHORIZATION

In connection with an application for insurance on the lives of my children: I hereby authorize any physician, medical practitioner, health care provider, hospital, clinic, insurance company, the Medical Information Bureau (MIB) or any other organization or person that has records or knowledge of them or their health to give such information to the Medical Director of The Savings Bank Life Insurance Company of Massachusetts (the Company) or any consumer reporting agency acting on its behalf. This may include, but is not limited to, findings or records of: medical care, examinations, psychiatric or psychological care, drug or alcohol use history or previous disability or surgery.

- 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.
- A photocopy of this form shall be as valid as the original and I understand that I may have a copy of this form upon request. The authorization is valid for 30 months from the date of my signature shown below.
- By signing below I agree to the terms of this authorization and acknowledge that I have read and understand it.

_____	_____	_____
DATE	SIGNATURE OF APPLICANT	RELATIONSHIP TO CHILDREN

ABBREVIATED NOTICE OF INFORMATION PRACTICES

- Personal information about your children may be collected from other parties.
- Personal and privileged information about your children may in certain circumstances be disclosed to third parties without your authorization.
- You have a 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.