SBLI® THE NO NONSENSE LIFE INSURANCE COMPANY®

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

LIFE INSURANCE APPLICATION
Part I

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

A. PRODUCT INFORMATION

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

B. PROPOSED INSURED INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

Trustee's Name	Address	Signature

Name of Proposed Insured

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

1. Primary Beneficiaries

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

2. Contingent Beneficiaries

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

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

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

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

Personal Section

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

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

Business Section

6.Purpose of Insurance: ☐ Buy-Sell ☐ Key Employee ☐ Secure Credit ☐Other (Specify):	7. Is the business a: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other

8.Type of Business	9. How long has the business been established?

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

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

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

F. PROPOSED INSURED PERSONAL HISTORY

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

_____
Name of Proposed Insured

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

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

Question #	Explanation

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

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

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

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

H. DIVIDEND OPTIONS *(If this section is left blank or a selected option is not available, the default option will be Accumulate at Interest)*

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

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

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

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

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

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

Name of Proposed Insured	Social Security Number	Date of Birth

K. AUTHORIZATION TO COLLECT AND DISCLOSE INFORMATION

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

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

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

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

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

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

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