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 II

Professional health care provider ("care provider") means persons licensed as: medical physicians; chiropractors; physical therapists; psychologists; and drug, alcohol, or mental health counselors. **Professional health care treatment facility ("treatment facility")** includes: hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; and facilities or offices staffed or run by care providers.

A. PROPOSED INSURED INFORMATION

1. Full Name (First, Middle, Last)	2. Date of Birth (mm/dd/yyyy)	3. SSN

B. MEDICAL HISTORY *Please answer ALL medical history questions. Do not leave any questions blank. Explain "Yes" Answers in DETAILS*

1. Primary Care Provider ("PCP")

Provide name, address and phone number of your PCP. For the past 5 years, describe dates, reasons consulted, and any treatments or medications prescribed in Section C, DETAILS, below. *(If no PCP, provide names, addresses and phone numbers of care providers last seen, dates and the reasons for the visits. If none, state "NONE").*

Name and address of PCP (or other care provider)	Phone Number	Dates Consulted	Reasons for Consultation	Treatments and Medications Prescribed

2. Build

a. Height ft. in.	b. Weight lbs.	c. Have you had any weight change in excess of 10lbs. in the past year? ☐ Yes ☐ No

3. Personal Health History (For any "Yes" answers, provide details in Section C, DETAILS, below)

a. Have you ever had, been treated for, or been medically advised to be treated for any of the following?

	Yes	No		Yes	No		Yes	No
1. Anemia or other Blood Disorder	☐	☐	16. Dizziness/Fainting	☐	☐	31. Paralysis	☐	☐
2. Angina/Chest Pain	☐	☐	17. Emphysema	☐	☐	32. Pituitary Disorder	☐	☐
3. Anxiety/Depression/Mental Disorder	☐	☐	18. Epilepsy/Seizures	☐	☐	33. Prostate Disorder	☐	☐
4. Asthma	☐	☐	19. Gastrointestinal/Esophageal Disorder/Ulcer	☐	☐	34. Respiratory Disorder, Chronic Cough, Spitting up Blood	☐	☐
5. Backache or Sciatica	☐	☐	20. Genito-urinary Disorder	☐	☐	35. Any Sexually Transmitted Disease	☐	☐
6. Bone, Joint or Arthritis	☐	☐	21. Heart Attack or Heart Disease	☐	☐	36. Shortness of Breath	☐	☐
7. Bronchitis	☐	☐	22. Heart Murmur/Rheumatic Fever	☐	☐	37. Skin Disorder	☐	☐
8. Cancer	☐	☐	23. Hepatitis	☐	☐	38. Sleep Apnea	☐	☐
9. Chronic Headaches	☐	☐	24. High Blood Pressure	☐	☐	39. Stroke	☐	☐
10. Circulatory Disorder	☐	☐	25. Kidney Disorder	☐	☐	40. Sugar, Protein, or Blood in Urine	☐	☐
11. Clotting Disorder	☐	☐	26. Lupus(SLE)/Scleroderma	☐	☐	41. Suicide Attempt	☐	☐
12. Colitis/Ileitis	☐	☐	27. Lymph Gland Disorder	☐	☐	42. Thyroid Disorder	☐	☐
13. Diabetes	☐	☐	28. Multiple Sclerosis	☐	☐	43. Tuberculosis	☐	☐
14. Disease of the Brain or Nervous System	☐	☐	29. Palpitations/Arrhythmia	☐	☐	44. Tumor, Mass or Lump	☐	☐
15. Disease of the Liver or Gallbladder	☐	☐	30. Pancreatitis or other Disorder of the Pancreas	☐	☐			

b. In the past 5 years, have you:

1. consulted with or received treatment from a care provider or treatment facility?	☐Yes ☐No
2. had an EKG, X-ray, or other diagnostic test, other than an AIDS-related test?	☐Yes ☐No
3. been advised to have any diagnostic test, other than an AIDS-related test, hospitalization or surgery that was not completed?	☐Yes ☐No
4. had medication prescribed for any other condition not listed in question 3(a), above?	☐Yes ☐No
5. ever received or claimed disability or hospital indemnity benefits or pension for any injury, sickness, disability or impaired condition?	☐Yes ☐No

Name of Proposed Insured

c. Have you ever:

1. sought or received advice, counseling or treatment by a care provider for the use of alcohol or drugs, including prescription drugs?.... ☐Yes ☐No
2. used cocaine, marijuana, heroin, narcotics, stimulants, sedatives, hallucinogens, controlled substance or any other drug, except as legally prescribed by a physician?..... ☐Yes ☐No
3. been diagnosed as having or been treated by a care provider for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? ..... ☐Yes ☐No
4. used alcoholic beverages? ..... ☐Yes ☐No
   If "Yes", type: Frequency: Amount:

d. Do you have any symptoms or knowledge of any other conditions that are NOT disclosed above? ..... ☐Yes ☐No

4. Family History

a. Is there a history of diabetes, cancer, high blood pressure, heart or kidney disease, cardiovascular disease, alcoholism, mental illness, or suicide in your family?..... ☐Yes ☐No

b. Please complete the following:

	Age if Living	State of Health	Age of Death	Cause of Death	History of diabetes, cancer, heart disease or cardiovascular disease?
Father					☐Yes ☐No _____ _____ Age of Onset Type
Mother					☐Yes ☐No _____ _____ Age of Onset Type
☐Brother ☐Sister					☐Yes ☐No _____ _____ Age of Onset Type
☐Brother ☐Sister					☐Yes ☐No _____ _____ Age of Onset Type
☐Brother ☐Sister					☐Yes ☐No _____ _____ Age of Onset Type
☐Brother ☐Sister					☐Yes ☐No _____ _____ Age of Onset Type
☐Brother ☐Sister					☐Yes ☐No _____ _____ Age of Onset Type
☐Brother ☐Sister					☐Yes ☐No _____ _____ Age of Onset Type

C. DETAILS *For any "Yes" answers. Identify applicable question. If additional space is needed, use overflow form.*

State conditions, diagnoses, dates, durations, treatments, tests, medications prescribed and names, phone numbers and addresses of all care providers and treatment facilities.

Name of Proposed Insured

D. AGREEMENT AND SIGNATURES

I, the Proposed Insured signing below, agree that I have read all of the statements contained in this entire application, or they have been read to me I understand and agree that no Producer is authorized to (a) accept risks or pass upon insurability; (b) make or modify contracts; (c) waive the Company's rights or requirements; or (d) waive any information the Company requests.

I represent: (1) the statements and answers given in the entire application are true, complete, and correct to the best of my knowledge and belief; (2) that The Savings Bank Life Insurance Company of Massachusetts, believing the statements and answers to be true, complete, and correct, shall rely and act on them, and (3) the insurance being applied for is suitable for the Owner's insurance needs.

I acknowledge that I have received a copy or I have been read a copy of the Notice to Proposed Insured and Owner.

I agree that:
(a) I will notify the Company if any statement or answer given in the entire application changes prior to policy delivery; and
(b) except as provided in the Conditional Receipt Agreement (CRA), I understand and agree that even if I paid a premium, no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless the following three conditions are all met:

(1) the policy has been delivered and accepted;
(2) the full first modal premium for the delivered policy has been paid in full; and
(3) there has been no change in the health of the Proposed Insured that would change the answers to any questions in the application, or any amendments thereto, before conditions (1) and (2) above have occurred.

I understand and agree that if all three conditions are not met:
- no insurance coverage will become effective; and
- the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

Signature of Proposed Insured **X**_____	Date	City, State

E. SIGNATURE(S) OF INTERVIEWER(S) – TO BE SIGNED BY ALL INTERVIEWERS, AS APPLICABLE

I certify that the information supplied by the Proposed Insured has been truthfully and accurately recorded on the Part II application.

If Producer recorded information:

Writing Producer Name	Date	Writing Producer Number
Writing Producer Signature **X**_____	**Countersigned (Licensed resident Producer if state required)** **X**_____	

If Tele-interviewer recorded information:

Name	Date

If Paramedical recorded information:

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

_____ Name of Proposed Insured

F. CUSTOMER IDENTITY INFORMATION :

To be completed by Producer or Paramed in physical proximity to the Proposed Insured (and Owner if different than Insured).

I have reviewed the Proposed Insured and Owner's (if applicable) identity document presented and recorded the following information:

Proposed Insured (and Owner if applicable) Name:		
Street Address:	**City and State:**	**Zip Code:**
Type of ID (Individual) (e.g. Drivers License):		
Type of ID Document (Corporation/Trust) (e.g. Certificate of Good Standing or Trust):		
ID Number:	**Expiration Date:**	
Signature of Producer or Paramed Authenticating Customer's Identity: **X**_____		
Producer/ Paramed Number:	**Date:**	