

**BOSTON MUTUAL LIFE INSURANCE COMPANY**

120 Royall Street • Canton, MA 02021 1-800-669-2668 Ext. 473

**EVIDENCE OF INSURABILITY FORM FOR GROUP INSURANCE**

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

Refer to the Group Policy for types of coverage available and eligible amounts of insurance

**PLEASE COMPLETE IN FULL**

**IMPORTANT**  
Submit with completed Enrollment form.

**EMPLOYER SECTION**

|                   |                                             |                     |
|-------------------|---------------------------------------------|---------------------|
| Group #           | Div. #                                      | Employer/Group Name |
| Social Security # | Employee Name (Last, First, Middle Initial) |                     |
| Telephone #       | Address                                     |                     |

**PROPOSED INSURED(S)**

| Name | Relationship | Date of Birth | Height | Weight |
|------|--------------|---------------|--------|--------|
|      |              |               |        |        |
|      |              |               |        |        |
|      |              |               |        |        |
|      |              |               |        |        |
|      |              |               |        |        |

**REASON****NEW**

- ☐ Late Applicant  
☐ Applying for Coverage in Excess of the Guaranteed Amount  
☐ Applying for Supplemental Coverage  
☐ Other \_\_\_\_\_

**CHANGE**

- ☐ Increase in Coverage  
☐ Adding Spouse  
☐ Increasing Spouse  
☐ Adding Dependent Child(ren)  
☐ Other \_\_\_\_\_

**APPLYING FOR ...**

| <u>YOU</u>                                     | <u>LIFE</u>                        | <u>AD&amp;D</u>     | <u>VOLUNTARY LIFE</u>          | <u>VOLUNTARY AD&amp;D</u>     |
|------------------------------------------------|------------------------------------|---------------------|--------------------------------|-------------------------------|
| Current Insurance                              | _____                              | _____               | _____                          | _____                         |
| Additional Insurance Requested                 | _____                              | _____               | _____                          | _____                         |
| Total New Coverage                             | _____                              | _____               | _____                          | _____                         |
| <input type="checkbox"/> Short Term Disability | \$ _____<br><i>Weekly Benefit</i>  |                     |                                |                               |
| <input type="checkbox"/> Long Term Disability  | \$ _____<br><i>Monthly Benefit</i> |                     | <input type="checkbox"/> Other | \$ _____                      |
| <br><u>YOUR SPOUSE</u>                         | <br><u>LIFE</u>                    | <br><u>AD&amp;D</u> | <br><u>VOLUNTARY LIFE</u>      | <br><u>VOLUNTARY AD&amp;D</u> |
| Current Insurance                              | _____                              | _____               | _____                          | _____                         |
| Additional Insurance Requested                 | _____                              | _____               | _____                          | _____                         |
| Total New Coverage                             | _____                              | _____               | _____                          | _____                         |
|                                                |                                    |                     | <input type="checkbox"/> Other | \$ _____                      |

**EVIDENCE OF INSURABILITY**

|                             |                                                                                             |                |                |                           |                                                                                                                                                   |
|-----------------------------|---------------------------------------------------------------------------------------------|----------------|----------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| 1A.<br>Existing<br>Coverage | Please list all life insurance and/or annuity contacts now in-force or pending on your life |                |                |                           |                                                                                                                                                   |
|                             | Name of Company<br>(if replacement include Policy No.)                                      | Life<br>Amount | AD&D<br>Amount | Year Issued<br>or Pending | Do you intend to replace or change this coverage<br>if you and your dependents are approved for the<br>insurance applied for on this application? |
|                             |                                                                                             |                |                |                           | <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                          |
|                             |                                                                                             |                |                |                           | <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                          |

**1B. To be Completed for ALL Proposed Insured(s) if Required by the Group Insurance Contract**

Have you used any form of tobacco products (cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches) within the past 12 months? \*\*      **Employee**   ☐ YES   ☐ NO      **Spouse**   ☐ YES   ☐ NO

\*\* *I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted to the amount which the premiums would have purchased if the questions had been answered correctly.*

2. Have ANY of the proposed insureds ever had or been told by a member of the medical profession that they had:
- A. 1) asthma or emphysema; 2) high blood pressure, stroke, heart or circulatory disease or disorder; 3) intestinal disease or disorder or ulcer; 4) diabetes; 5) leukemia, cancer, tumor or malignancy; 6) epilepsy, mental or nervous disease or disorder; 7) kidney or genito-urinary disease or disorder; or 8) disorder of the back, muscles, bones or joints?      ☐ YES   ☐ NO
- B. Have any of the proposed insureds been treated for or been diagnosed by a member of the medical profession as having an immune deficiency disorder or AIDS (Acquired Immune Deficiency Syndrome)?      ☐ YES   ☐ NO
- C. In the past 5 years, have any of the proposed insureds; 1) been hospitalized or had hospitalization recommended; 2) had a physical examination or medical test with other than normal results?      ☐ YES   ☐ NO
- D. Do you or your spouse: 1) fly, or intend to fly, as pilot or crew member; 2) race or test any form of vehicle; 3) scuba dive; 4) hang glide or sky dive?      ☐ YES   ☐ NO
- E. Has any proposed insured used on a regular basis or are they currently using or ever received treatment or consultation for the use of heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs or alcoholism?      ☐ YES   ☐ NO

3. Details for questions 2 - A, B, C, D, E answered "YES". Include question number.

| Name | Disease or Injury | Date (s) | Details/Treatment | Names & Address of Attending Phy's & Hospitals |
|------|-------------------|----------|-------------------|------------------------------------------------|
|      |                   |          |                   |                                                |
|      |                   |          |                   |                                                |
|      |                   |          |                   |                                                |
|      |                   |          |                   |                                                |
|      |                   |          |                   |                                                |
|      |                   |          |                   |                                                |

**REPRESENTATIONS AND NOTICE TO APPLICANTS**

I/we represent that the statements and answers in this Evidence of Insurability form are complete and true to the best of my/our knowledge and belief. I/we agree that this form shall form the basis for and become a part of the consideration for the insurance applied for.

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.

\_\_\_\_\_  
Signature of Applicant (Employee/Member)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signed & Dated at (City, State)

\_\_\_\_\_  
Signature of Applicant (Other than Employee/Member)  
(Employee/Member if the proposed insured is under 15)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signed & Dated at (City, State)

**Thank you for considering Boston Mutual Life Insurance Company as your insurance carrier.  
Your application will receive our immediate and full consideration.**