APPLICATION TO THE BOSTON MUTUAL LIFE INSURANCE COMPANY

for Employee Optional Life Insurance under the _____ **Program.**

NAME OF EMPLOYEE

_____
(LAST) *(FIRST)* *(MIDDLE)*

Department	Date of Birth			Earnings
	_____ *(MONTH, DAY, YEAR)*	❑ Male ❑ Female	❑ Married ❑ Single	

DESIGNATION OF BENEFICIARY – Where more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiary *(or beneficiaries)* as survive you, unless otherwise provided by percentage shown hereon. If no designated beneficiary survives you, settlement will be made as provided in the policy.

1. _____ _____ _____ %
BENEFICIARY *RELATIONSHIP* *% TO BE PAID*

2. _____ _____ _____ %
BENEFICIARY *RELATIONSHIP* *% TO BE PAID*

3. ❑ Same as indicated for Basic Coverage.

AMOUNT OF INSURANCE *(Check one but not both)*

❑ I hereby apply for my Maximum Allowable Insurance and Authorize Payroll Deductions as required. I further request that if in the future I become entitled to further additional insurance because of an increase in annual salary, the premium for such additional insurance be automatically deducted from my salary without my further approval.

❑ I desire only $ _____ *(fill in the amount of insurance desired)* of Optional Insurance and Authorized Payroll Deductions as required. I do not desire additional insurance automatically based upon any increase in salary.

_____ _____
DATE *SIGNATURE OF INSURED*

FORM GO-7A ED. 9-62 221-035 5/02

In compliance with the Fair Credit Reporting Act, we are informing you that as part of our normal necessary procedure for processing applications, an investigative consumer report may be prepared which will provide applicable information concerning your character, general reputation, personal characteristics and mode of living. This information will be obtained through personal interviews with your friends, neighbors and associates. Upon written request to the New Business Department at the above address, disclosure of the nature and scope of the report will be provided.

NAME OF EMPLOYEE

Certificate of Department Head	Please Check-off Employee Age Classification	Insurance: Amount	Begins Increase	Terms/Changes
1) Annual Salary or Compensation $_____	❑ A	$		
2) Date Salary became Effective _____	❑ B	$		
3) Maximum Optional Insurance Allowable $_____ *(use Base Salary excluding overtime)*	❑ C	$		
DATE *(DEPT. HEAD SIGNATURE)*	❑ D	$		

PLEASE COMPLETE AND SIGN

1. Mailing Address _____ *STREET* *CITY* *ZONE* *STATE*
2. Date of Birth _____ 3. Height _____ 4. Weight _____
5. Do you know of any impairment now existing in your Health or Physical Condition? YES ❑ NO ❑
   If "YES" give particulars _____
6. Have you had any illness during the past three years? YES ❑ NO ❑
   If "YES" give approximate dates with particulars, including names of attending physicians, if any. _____

AUTHORIZATION

I, the undersigned, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the BOSTON MUTUAL LIFE INSURANCE COMPANY any such information.
I acknowledge receipt of the Notification to the Proposed Insured. A photocopy of this authorization shall be as valid as the original.

DATE *SIGNATURE*

To Be Detached and Retained by Proposed Insured

NOTIFICATION TO PROPOSED INSURED *(Parent or Guardian if a Minor)*

"Information regarding your insurability will be treated as confidential. The Boston Mutual Life Insurance Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file."

"Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. *(Medical information will be disclosed only to your attending physician.)* If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660."

"The Boston Mutual Life Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted."