



STATEMENT 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

EMPLOYEE/EMPLOYER

Submit with completed Enrollment form.

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 [(if pregnant, pre-pregnancy 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 _____

INSURANCE

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

AUTHORIZATION TO OBTAIN INFORMATION

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. (*formally known as Medical Information Bureau, Inc.*), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

MIB REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

CONSUMER REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report, which may include a report from MIB, Inc. (*formerly Medical Information Bureau, Inc.*) on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

REPRESENTATIONS AND NOTICE TO APPLICANTS

I/we have read the Statement of Insurability form and represent that the statements and answers 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.

CAUTION: Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Proposed Insured (*Employee/Member*) Date Signed & Dated at (*City, State*)

Signature of Proposed Insured (*Other than Employee/Member*) Date Signed & Dated at (*City, State*)
(*Employee/Member if the proposed insured is under [15]*)

MUST BE USED WITH HIPAA FORM DESIGNATED FOR YOUR STATE