



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 . . .

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

YOUR SPOUSE	LIFE	AD&D	VOLUNTARY LIFE	VOLUNTARY AD&D
Current Insurance	_____	_____	_____	_____
Additional Insurance Requested	_____	_____	_____	_____
Total New Coverage	_____	_____	_____	_____
			<input type="checkbox"/> Other	\$ _____

EVIDENCE OF INSURABILITY

1A. Existing Coverage	Please list all life insurance and/or annuity contacts now in-force or pending on your life				
	Name of Company <i>(if replacement include Policy No.)</i>	Life Amount	AD&D Amount	Year Issued or Pending	Do you intend to replace or change this coverage if you and your dependents are approved for the 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** I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted to the amount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 Phv'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) _____ Date _____ Signed & Dated at (City, State) _____
(Employee/Member if the proposed insured is under 15)

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