

PART A: ACCIDENT INSURANCE APPLICATION

1. Proposed Insured (<i>Employee</i>)				2. <input type="checkbox"/> M Gender <input type="checkbox"/> F		7. Proposed Insured (<i>Spouse</i>)		8. <input type="checkbox"/> M Gender <input type="checkbox"/> F	
3. Date of Birth	4. Age	5. Place of Birth State	6. Phone No. ()			9. Date of Birth		10. Age	
11. Present Residence No. Street City State Zip									
12. Mailing Address (<i>if different</i>)						13. S.S. No. (<i>Employee</i>)			
14. Are you actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO									
15. Plan (<i>select one</i>) <input type="checkbox"/> Employee Only-Weekly Premium [] <input type="checkbox"/> Employee/Children-Weekly Premium [] <input type="checkbox"/> Employee/Spouse-Weekly Premium [] <input type="checkbox"/> Employee/Spouse/Children-Weekly Premium []									
16. Additional Riders: <input type="checkbox"/> Enhanced Emergency Room Benefit Rider (\$100 per unit) # of Units _____ <input type="checkbox"/> Enhanced Physician Office/Urgent Care Benefit Rider (\$25 per unit) . . . # of Units _____ <input type="checkbox"/> Occupational HIV Benefit Rider (\$10,000 per unit) # of Units _____ <input type="checkbox"/> Other _____						Base Plan Weekly Premium \$ _____ \$ _____ \$ _____ \$ _____ \$ _____ Total Weekly Premium \$ _____			
17. Beneficiary Primary: _____ Relationship _____									
18. Employer						Date of Employment		Employee No.	
19. Proposed Dependents applying for the Children's Rider									
Name (<i>first</i>) (last)		Date of Birth			Age	Gender M or F	Relationship to Applicant		
		Mo.	Day	Yr.					
20. Other Information: 1. Do you or any person to be insured have any accident insurance, excluding an employer's group plan, or any application for such insurance pending? <input type="checkbox"/> YES <input type="checkbox"/> NO 2. Will this insurance replace any other coverage? (<i>If yes, complete state replacement form if required</i>) <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES" to #1 OR #2, provide name of insurance company and type of insurance: _____									
21. Special Requests									

AGREEMENT AND DECLARATION - Read Carefully Before Signing
 I represent that the statements and answers written in this application in part A and any supplements are complete and true to the best of my/our knowledge and belief, and it is agreed that:

A. This application and any supplement shall form the basis for and become a part of any policy issued.

B. The agent has no authority to waive the answer to any question in, or to modify, the application.

C. The insurance applied for shall be in force at 11:59 PM on the date of the application signed by me, provided that the Company approved the application without any modification as to plan, amount of premium, and, further provided that the Company receives the first premium payment from my employer within 90 days from the date hereof. If the first premium is not received within

90 days, no insurance will become effective. If the application is approved with any such modification, the insurance shall not take effect until the policy has been delivered to and accepted by me and shall not take effect if there has been a change in the health of any person to be insured as stated since the date of the application.

D. The employee will be the owner unless otherwise stated. In the event of the employee's death, ownership will transfer to the primary beneficiary.

E. I have received a copy of Boston Mutual's Notice of Information Privacy Practices and an Outline of Coverage, (*where applicable*).

F. CAUTION: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Employee (*Owner*) _____

Witnessed (*Licensed Agent*) _____ (please sign and print your name)

Dated _____ at _____
(Month, Day, Year) (City, State)

NPN # _____
(National Producer Number)

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