

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 ROYALL STREET • CANTON, MA 02021

SPECIFIED DISEASE ENROLLMENT FORM

PART A

Proposed Insured <i>(First, Middle, Last)</i>		Social Security/ITIN	Gender	Date of Birth	Age
Residential Address <i>(no P.O. Box)</i>		City	State	Zip	
Mailing Address		Occupation	Hours Worked	Date of Hire	
Employer	Daytime Phone No.	Beneficiary Name for Proposed Insured/Relationship <i>(estate unless designated otherwise)</i>			
Spouse's Name <i>(if applying for coverage)</i>			Gender	Spouse Date of Birth	Age
Special Request			Proposed Insured	Spouse	
Are you actively at work?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
Has your spouse received medical advice or treatment or been advised to receive medical tests, by a member of the medical profession but has not received the results of those tests within the past six months?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you used any tobacco products in the last 12 months?			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
As of the date of this application, is there any other specified disease, disability, or accident insurance in force or applied for on any proposed insured? If "Yes", list company name, person covered, policy number, type and amount of coverage and the specified disease(s) covered.			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
SPECIFIED DISEASE: <input type="checkbox"/> with Cancer <input type="checkbox"/> without Cancer					
<input type="checkbox"/> Proposed Insured: Benefit Amount \$ _____		Premium Amount \$ _____			
<input type="checkbox"/> Spouse: Benefit Amount \$ _____		Premium Amount \$ _____			
Riders: <input type="checkbox"/> Dependent Children's Rider Premium \$ _____		<input type="checkbox"/> Genetic Screening Rider Premium \$ _____			
<input type="checkbox"/> Health Screening Rider Premium \$ _____		<input type="checkbox"/> Extended Loss Rider Premium \$ _____			
<input type="checkbox"/> Occupational HIV Benefit Rider \$ _____		Total weekly premium: \$ _____			
To the best of your knowledge and belief:			Proposed Insured	Spouse	
1. Within the last 5 years, have you been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or tested positive for antigens or antibodies to an "AIDS" virus?			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
2. Within the last 5 years, have you been told by a physician that you needed an organ transplant, or been diagnosed or treated by a physician for a) a stroke or transient ischemic attack (TIA), b) heart attack or other heart condition, or any abnormality of the heart or circulatory system; c) diabetes except gestational diabetes; d) Any disease or disorder of the liver or pancreas; e) kidney (renal) failure or end stage kidney (renal) disease; f) emphysema or lung disease; g) Alzheimer's Disease; h) Lupus, Cystic Fibrosis, or Sickle Cell Anemia; i) paralysis of at least two limbs; or j) disease or disorder of the nervous system.			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
3. Within the last 2 years have any proposed insured taken 3 or more medications for high blood pressure or been diagnosed or treated for alcohol or drug abuse?			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
4. Answer only if cancer coverage is being selected: in the last 5 years have any proposed insured been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's disease, leukemia, lymphoma, or malignant tumor by a member of the medical profession? Cancer does not include basal cell or squamous cell carcinoma.			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	

AGREEMENT & DECLARATION – Read Carefully Before Signing: I represent that the statements and answers written in this enrollment form parts A & B and any supplements are complete and true to the best of my/our knowledge and belief, and it is agree that:

- A. This enrollment form and any supplement shall form the basis for and become a part of any certificate issued.
- B. The agent has no authority to waive the answers to any question in, or modify the application.
- C. The insurance applied for shall be in force on the date of the enrollment form signed by me, provided that the Company approves the enrollment form without any modification, as to plan, amount of premium, and, further provided that the Company receives the first premium payment within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance shall 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 proposed insured will be the owner unless otherwise stated in the Special Request section.
- E. I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.
- F. I have received a copy of Boston Mutual Life Insurance Company's Notice of Information Privacy Practices and any outline of coverage that is required by the state.

CAUTION: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

No person to be covered under this plan is also covered by Medicaid.

The certificate provides limited benefits. Review your certificate carefully.

Date _____ Signature of Proposed Insured _____ Signed at _____

Date _____ Signature of Agent _____ Agent NPN Number _____

Underwritten by: Boston Mutual Life Insurance Company

SPECIFIED DISEASE ENROLLMENT FORM

PART B

To be completed for any proposed insured who is applying for Benefit Amounts in excess of \$50,000:

Name of Proposed Insured	Height	Weight
A.		
B.		
C.		
D.		
E.		

To the best of your knowledge and belief:

1. Please list all prescription drugs any proposed insured is currently taking.

Proposed Insured A _____

Proposed Insured B _____

Proposed Insured C _____

Proposed Insured D _____

Proposed Insured E _____

HOME OFFICE USE ONLY

Guarantee Issue Amount _____

Proposed Insured _____

Spouse _____