

INDIVIDUAL LIFE INSURANCE APPLICATION Legacy Life – Final Expense

The Savings Bank Mutual Life Insurance Company of Massachusetts

P.O. Box 4046, Woburn, MA 01888 Telephone (800) 694-7254 <u>www.sbli.com</u>

In this Application, "you" and "your" refer to the Proposed Insured.

"SBLI" refers to The Savings Bank Mutual Life Insurance Company of Massachusetts.

Full Name (First, Middle Initial, Last) Date of Birth Social Security Number Gender Are you a legal resident of the United States? Helight Weight In the past 12 months, have you used any form of tobacco or nicotine replacement therapy? Pyes No Home Address City State Zip E-mail Address (If different) City State Zip E-mail Address (If different) City State Zip E-mail Address Cell Phone Home Phone Preferred Method of Contact Penden Postal Mail Postal Mailing Address (If different) Social Security Number Relationship to Proposed Insured Full Name (First, Middle Initial, Last) Social Security Number Relationship to Proposed Insured Full Name (First, Middle Initial), Last) City State Zip E-mail Address (If different) City State Zip Femail Address (If different) City State Zip Full Name (First, Middle Initial), Last) Preferred Method of Contact Text Phone E-mail Phone E-mail Phone December Preferred Method of Contact Text Phone December Preferred Method of C	1. PROPOSED INSURED INFORMATION	ON							
City State Zip	Full Name (First, Middle Initial, Last)		Date	Date of Birth Sc		Social Security Number			Gender
City State Zip						·			
City State Zip			_	1	<u> </u>				
Home Address City State Zip			Height	Weigl					
Mailing Address (If different) City State Zip	(If "No", you are not eligible to app	ly) ☐ Yes ☐ No				form of tobacco or nicotine replacement			
Mailing Address (If different) City State Zip						1			Yes □ No
E-mail Address Cell Phone	Home Address		City			State		Zip	
E-mail Address Cell Phone									
E-mail Address Cell Phone	AA :1: A I I (15 1:55 1)		6.1			6			
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Insurance Rider covered at no extra cost upon application.									
							nay be		
Child Benefit Amount	Child Benefit Amount								

Name of Proposed Insured:		SSN:		Date of E	Date of Birth:		
Children you'd like to insure			Data of Dirth		Condor		
Full Name			Date of Birth		Gender		
A WILL ARE VOLID DENETICIARIES. Charge will be d	listributed equal	ly if not colocted					
4. WHO ARE YOUR BENEFICIARIES? - Shares will be d Primary Beneficiaries - % of shares must equal 100%	istributea equali	y if not selected					
Full Name	Relationship to	NOU.	% Share	Date of Bi	rth		
Turriturite	Relationship to	you	70 Share	Date of bil			
Contingent Beneficiaries - Only in event that no Prima	ary Panaficiary s	urvivas vau % a	f charac must agus	J 100%			
Full Name	Relationship to		% Share	Date of Bi	rth		
Tan Name	relationship to	, you	70 Share	Date of Bil			
5. YOUR MEDICAL INFORMATION Part A							
	been confined to	a hospital (othe	er than childbirth) o	r bedridde	n.		
1. Are you currently, or in the last 6 months have you been confined to a hospital (other than childbirth) or bedridden, or diagnosed by a licensed medical professional as having a terminal medical condition that is expected to result							
in death within the next twelve (12) months?							
2. Do you require a wheelchair due to a chronic illness or disease, or do you require assistance with the							
activities of daily living, such as bathing, dressing, eating, or toileting?							
3. In the last 5 years, have you received home health care/assisted living care, or been confined to a nursing home							
or psychiatric facility? 4. Have you ever been diagnosed or treated by a licensed medical professional for Acquired Immune Deficiency							
Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV)?							
5. In the past 2 years, has a licensed medical professional advised you to have any tests (excluding those related to							
the AIDS virus), surgery or hospitalization which h	•	-			□ Yes □ No		
6. Has a licensed medical professional ever advised y	ou to have an o	rgan transplant,	or diagnosed you	with, or			
given you treatment for Amyotrophic Lateral Scler	rosis, Cirrhosis o	f the Liver, Dem	entia, Alzheimer's	disease, or	☐ Yes ☐ No		
are you currently receiving Kidney Dialysis?							
7. Have you within the last six months received treatr			a licensed medical	profession	al		
for any type of Cancer except for Basal or Squamo							
8. Have you tested positive by a licensed medical pro Have you tested positive by a licensed medical pro			et 30 days?		☐ Yes ☐ No		
Have you been hospitalized by a licensed medical pro				9 within th	ne ☐ Yes ☐ No		
last 90 days?	p. 0100010110110	to complice	2		☐ Yes ☐ No		
9. Except for traffic violations, In the last 5 years have you been convicted of or plead guilty to a misdemeanor or							
felony, or are you awaiting trial for a felony?	_ ,	or prede	_ ga, to a miliater		☐ Yes ☐ No		
If you answered yes, did the conviction or guilty	plea result conf	finement in a pr	ison or correctiona	I facility?	☐ Yes ☐ No		

	Name of Proposed Insured:	ame of Proposed Insured:		SSN:		Date of Birth:		
Part B								
	1. Have you been diagnosed with, or received treatment by a licensed medical professional for complications of Diabetes, such as: Retinopathy, Amputation, Neuropathy, Diabetic Shock, or Coma?							
2. In the past 36 months, have you been diagnosed with, or received treatment by a licensed medical professional								
	for any type of Cancer inclu	ding Melanoma	(except for Basal	or Squamous Cell	Carcinoma), Lymp	homa, or	☐ Yes ☐ No	
	Leukemia, or has a licensed n	nedical professior	nal performed an	amputation on you	due to any complic	cation for		
any impairment?								
	3. In the past 24 months, have y	_		=				
	for: Heart Attack, Stroke (TIA		-		eurysm, Heart Valve	e Disease,	☐ Yes ☐ No	
	Congestive Heart Failure, Card							
	4. In the past 36 months, have an	•			•			
	hallucinogens, heroin, cocaine						1 1 1 2 2 2 1 1 1 1 1 1	
	medical professional, a license	•		-	_	treatment		
	for alcohol or drugs, you have							
	5. Has a licensed medical profess a pacemaker?	ionai piaced you d	on a defibrillator, a	iavisea you to use o	xygen equipment, o	rinsertea	☐ Yes ☐ No	
ī	Part C							
	1. Within the last 2 years, have y	rou heen diagnosi	ed with received t	treatment by a lice	nsed medical profes	sional for		
	Bipolar, Schizophrenia or have	_		-	-	ssional ioi	☐ Yes ☐ No	
	2. Within the last 5 years, have y					ofessional		
	for: Systemic Lupus Erythema	_		=	· · · · · · · · · · · · · · · · · · ·	Jic 331011a1	☐ Yes ☐ No	
	3. Within the last 5 years, have y					ofessional		
	for: Hepatitis C or Chronic Hep	_		•	-			
	Disease (COPD), or Emphysem		,			,		
6. DO YOU HAVE OTHER COVERAGE?								
	5. DO YOU HAVE OTHER COVERA	AGE?						
	 DO YOU HAVE OTHER COVERA Do you have any pending applica 		life insurance or a	innuity contracts wi	th us or any other c	company?	☐ Yes ☐ No	
		tions, or existing		•	-		☐ Yes ☐ No	
	Do you have any pending applica	tions, or existing		•	-		☐ Yes ☐ No	
	Do you have any pending applica Is this coverage intended to repla	tions, or existing ace or change any	life insurance or a	annuity contract in	force with us or any	y other		
	Do you have any pending applica Is this coverage intended to replace company?	tions, or existing ace or change any eplacing an existi	life insurance or a	annuity contract in	force with us or any	y other	☐ Yes ☐ No	
	Do you have any pending applica Is this coverage intended to replace company? Is the policy or contract you are reforming and the source of the contract of the source of	tions, or existing ace or change any eplacing an existing please complete	life insurance or a ing life insurance of the state required	annuity contract in or an annuity contract or dreplacement forn	force with us or any act in force with SBL and list below:	other	☐ Yes ☐ No	
	Do you have any pending applica Is this coverage intended to replace company? Is the policy or contract you are r	tions, or existing ace or change any eplacing an existing please complete	life insurance or a ing life insurance of the state required	annuity contract in	force with us or any	other	☐ Yes ☐ No ☐ Yes ☐ No	
	Do you have any pending applica Is this coverage intended to replace company? Is the policy or contract you are reforming and the source of the contract of the source of	tions, or existing ace or change any eplacing an existing please complete	life insurance or a ing life insurance of the state required	annuity contract in or an annuity contract or dreplacement forn	force with us or any act in force with SBL and list below:	other	☐ Yes ☐ No ☐ Yes ☐ No Replaced or	
	Do you have any pending applica Is this coverage intended to replace company? Is the policy or contract you are reforming and the source of the contract of the source of	tions, or existing ace or change any eplacing an existing please complete	life insurance or a ing life insurance of the state required	annuity contract in or an annuity contract or dreplacement forn	force with us or any act in force with SBL and list below:	other	☐ Yes ☐ No ☐ Yes ☐ No Replaced or Changed? ☐ Yes ☐ No	
	Do you have any pending applica Is this coverage intended to replacempany? Is the policy or contract you are refor any "Yes" answers to above, Insurance Compa	tions, or existing ace or change any eplacing an existing please complete	life insurance or a ing life insurance of the state required	annuity contract in or an annuity contract or dreplacement forn	force with us or any act in force with SBL and list below:	other	☐ Yes ☐ No ☐ Yes ☐ No Replaced or Changed?	
	Do you have any pending applica Is this coverage intended to replacempany? Is the policy or contract you are refor any "Yes" answers to above, Insurance Compa	tions, or existing ace or change any replacing an existing please complete any	r life insurance or a ing life insurance of the state required Name of	annuity contract in or an annuity contract or dreplacement forn	force with us or any act in force with SBL and list below:	other	☐ Yes ☐ No ☐ Yes ☐ No Replaced or Changed? ☐ Yes ☐ No	
	Do you have any pending applica Is this coverage intended to replacempany? Is the policy or contract you are refor any "Yes" answers to above, Insurance Compa	tions, or existing ace or change any replacing an existing please complete any	r life insurance or a ing life insurance of the state required Name of	annuity contract in or an annuity contract or dreplacement forn	force with us or any act in force with SBL and list below: Face Amount	other	☐ Yes ☐ No ☐ Yes ☐ No Replaced or Changed? ☐ Yes ☐ No	
	Do you have any pending applica Is this coverage intended to replacempany? Is the policy or contract you are refor any "Yes" answers to above, Insurance Compa	tions, or existing ace or change any replacing an existing please complete any	r life insurance or a ing life insurance of the state required Name of	or an annuity contract in or an annuity contract dreplacement form of Insured Please Choose a I	force with us or any act in force with SBL and list below: Face Amount	y other	☐ Yes ☐ No ☐ Yes ☐ No Replaced or Changed? ☐ Yes ☐ No ☐ Yes ☐ No	
	Do you have any pending applica Is this coverage intended to replacempany? Is the policy or contract you are refor any "Yes" answers to above, Insurance Compa	tions, or existing ace or change any replacing an existing please complete any	r life insurance or a ing life insurance of the state required Name of	or an annuity contract in or an annuity contract dreplacement form of Insured Please Choose a I	force with us or any act in force with SBL and list below: Face Amount Billing Option	y other	☐ Yes ☐ No ☐ Yes ☐ No Replaced or Changed? ☐ Yes ☐ No ☐ Yes ☐ No	
	Do you have any pending applica Is this coverage intended to replacempany? Is the policy or contract you are refor any "Yes" answers to above, Insurance Compa	tions, or existing ace or change any replacing an existing please complete any	r life insurance or a ing life insurance of the state required Name of	or an annuity contract in or an annuity contract of replacement form of Insured Please Choose a E	force with us or any act in force with SBL and list below: Face Amount Billing Option t is due with your sig	y other LI? t	☐ Yes ☐ No ☐ Yes ☐ No Replaced or Changed? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ication.	
	Do you have any pending applica Is this coverage intended to replacempany? Is the policy or contract you are refor any "Yes" answers to above, Insurance Compa	tions, or existing ace or change any replacing an existing please complete any	r life insurance or a ing life insurance of the state required Name of	or an annuity contract in or an annuity contract of replacement form of Insured Please Choose a E	force with us or any act in force with SBL and list below: Face Amount Billing Option It is due with your sig OR Social Security Paym	y other LI? t	☐ Yes ☐ No ☐ Yes ☐ No Replaced or Changed? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ication.	
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F	Do you have any pending applica Is this coverage intended to replacement? Is the policy or contract you are refor any "Yes" answers to above, Insurance Compa	tions, or existing ace or change any replacing an existing please complete any	n life insurance or a ling life insurance of the state required Name of Name	Please Choose a lead of the properties of the pr	Face Amount Billing Option It is due with your sig OR Social Security Paynt 2nd Wednesday	y other LI? t	☐ Yes ☐ No ☐ Yes ☐ No Replaced or Changed? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ication.	
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Name of Proposed Insured:		SSN:	Date of Bi	rth:				
8. AGREEMENTS AND SIGNATURES								
 8. AGREEMENTS AND SIGNATURES By signing below, I agree that: I have read this Application with all its statements and answers, or they have been read to me, and that: 1) I represent that the statements and answers are true, complete, and correct to the best of my knowledge and belief; 2) SBLI, believing the statements and answers to be true, complete, and correct, shall rely and act on them; and 3) The insurance being applied for is suitable for the Owner's insurance needs. I will notify SBLI if any statement or answer given in this application changes prior to Policy delivery; I understand that no Producer is authorized to: 1) Accept risks or pass upon insurability; 2) Make or modify contracts; 3) Waive SBLI's rights or requirements; or 4) Waive any information SBLI requests. I have received a copy, or I have been read a copy, of the Notice to Proposed Insured and Owner which contains my MIB and FCRA Notices. I understand that the Application includes this Application and all supplemental forms or amendments SBLI specifically designates as parts of the Application by attaching copies of them to any Policy delivered to the Owner. AS THE PAYOR, I authorize SBLI to charge my Premiums to my checking/savings account or Credit card/Debit card. This authorization is to remain in effect until I request cancellation. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. 								
Your Signature	Date							
x								
Signature of Owner/Applicant (if not Proposed Insu	ured) Date	Signature of Payor (if not	Signature of Payor (if not Owner/Applicant) Date					
Х		х						
Signature of Producer	Date	Producer #	License #					
x								
Producer Name Printed	Signed at (C	Signed at (City and state)		Rate class applied for:				
SBLI reserves the right to make administrative changes to the Application. No administrative changes will be ascribed to the Appli								
9. PRODUCER INFORMATION AND CERTIFICATION								
1. Does the Applicant have existing life insurance policies or annuity contracts? If "yes" submit the applicable state replacement form.								
2. Do you have any knowledge or reason to believe that a replacement of an existing life insurance policy or annuity contract is involved in this transaction or that any funds from an existing policy or contract will be used to pay premiums on this Policy?								
I certify that the responses in this application are, to the best of my knowledge, information and belief, complete and accurate. I have reviewed the purchase of the life insurance Policy as to suitability.								
Signature of Producer P	roducer Name Prin	ted	Date	Date				
Lead #: Source: Rate Code: Process Date:			l Underwritir	ng Stamp				