SBLI®

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 www.sbli.com

In this Application, "you" and "your" refer to the Proposed Insured.
"SBLI" refers to The Savings Bank Mutual Life Insurance Company of Massachusetts.

1. PROPOSED INSURED INFORMATION

Full Name (*First, Middle Initial, Last*)	Date of Birth	Social Security Number	Gender

Are you a legal resident of the United States? (If "No", you are not eligible to apply) ☐ Yes ☐ No	Height	Weight	In the past 12 months, have you used any form of tobacco or nicotine replacement therapy? ☐ Yes ☐ No

Home Address	City	State	Zip

Mailing Address (*If different*)	City	State	Zip

E-mail Address	Cell Phone	Home Phone	Preferred Method of Contact ☐ Text ☐ Phone ☐ E-mail ☐ Postal Mail

2. OWNER OF INSURANCE APPLIED FOR - *Complete only if Owner is to be other than the Proposed Insured*

Full Name (*First, Middle Initial, Last*)	Social Security Number	Relationship to Proposed Insured

Home Address	City	State	Zip

Mailing Address (*If different*)	City	State	Zip

E-mail Address	Cell Phone	Home Phone	Preferred Method of Contact ☐ Text ☐ Phone ☐ E-mail ☐Postal Mail

3. A. PRODUCT INFORMATION

The following pages include a Medical Information section. Your answers to the questions in that section will determine your eligibility for your initial Benefit Amount and any additional riders.

Payment of all Policy Benefits is subject to the terms and conditions of your Policy. Please read it carefully.

Level Coverage	Subject to the terms of your Policy, your selected Benefit Amount is eligible to be paid to your Beneficiary on the day your Policy is issued.
Benefit Amount	

3. B. DO YOU HAVE ANY CHILDREN YOU WOULD LIKE TO INSURE? - *Children, Grandchildren, or Great-Grandchildren*

Child Level Term Life Insurance Rider	Your selected rider Benefit Amount is payable to you as the beneficiary. Additional children may be covered at no extra cost upon application.
Child Benefit Amount	

Name of Proposed Insured:	SSN:	Date of Birth:

Children you'd like to insure

Full Name	Date of Birth	Gender

4. WHO ARE YOUR BENEFICIARIES? - *Shares will be distributed equally if not selected.*

Primary Beneficiaries - *% of shares must equal 100%*

Full Name	Relationship to you	% Share	Date of Birth

Contingent Beneficiaries - *Only in event that no Primary Beneficiary survives you. % of shares must equal 100%*

Full Name	Relationship to you	% Share	Date of Birth

5. YOUR MEDICAL INFORMATION Part A

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?	☐ Yes ☐ No
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?	☐ Yes ☐ No
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?	☐ Yes ☐ No
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)?	☐ Yes ☐ No
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 have not been received or completed?	☐ Yes ☐ No
6. Has a licensed medical professional ever advised you to have an organ transplant, or diagnosed you with, or given you treatment for Amyotrophic Lateral Sclerosis, Cirrhosis of the Liver, Dementia, Alzheimer's disease, or are you currently receiving Kidney Dialysis?	☐ Yes ☐ No
7. Have you within the last six months received treatment from or been diagnosed by a licensed medical professional for any type of Cancer except for Basal or Squamous Cell Carcinoma?	☐ Yes ☐ No
8. Have you tested positive by a licensed medical professional for COVID-19? Have you tested positive by a licensed medical professional for COVID-19 in the last 30 days? Have you been hospitalized by a licensed medical professional due to complications of COVID-19 within the last 90 days?	☐ Yes ☐ No ☐ Yes ☐ No ☐ 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? If you answered yes, did the conviction or guilty plea result confinement in a prison or correctional facility?	☐ Yes ☐ No ☐ Yes ☐ No

Name 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?	☐ Yes ☐ No
2. In the past 36 months, have you been diagnosed with, or received treatment by a licensed medical professional for any type of Cancer including Melanoma (except for Basal or Squamous Cell Carcinoma), Lymphoma, or Leukemia, or has a licensed medical professional performed an amputation on you due to any complication for any impairment?	☐ Yes ☐ No
3. In the past 24 months, have you been diagnosed with, or received treatment by a licensed medical professional for: Heart Attack, Stroke (TIA), Coronary Artery Disease, Angina (Chest Pain), Aneurysm, Heart Valve Disease, Congestive Heart Failure, Cardiomyopathy, or had Heart or Circulatory Surgery?	☐ Yes ☐ No
4. In the past 36 months, have any of the following occurred: have you used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other illegal drugs (excluding Marijuana use), except as prescribed by a licensed medical professional, a licensed medical professional has recommended that you receive counseling or treatment for alcohol or drugs, you have been convicted of driving under the influence of alcohol or drugs?	☐ Yes ☐ No
5. Has a licensed medical professional placed you on a defibrillator, advised you to use oxygen equipment, or inserted a pacemaker?	☐ Yes ☐ No

Part C

1. Within the last 2 years, have you been diagnosed with, received treatment by a licensed medical professional for Bipolar, Schizophrenia or have you been hospitalized for any mental or nervous disorder?	☐ Yes ☐ No
2. Within the last 5 years, have you been diagnosed with, or received treatment by a licensed medical professional for: Systemic Lupus Erythematosus, Parkinson's Disease, Multiple Sclerosis, or Sickle Cell Anemia?	☐ Yes ☐ No
3. Within the last 5 years, have you been diagnosed with, or received treatment by a licensed medical professional for: Hepatitis C or Chronic Hepatitis, Chronic Pancreatitis, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease (COPD), or Emphysema?	☐ Yes ☐ No

6. DO YOU HAVE OTHER COVERAGE?

Do you have any pending applications, or existing life insurance or annuity contracts with us or any other company?	☐ Yes ☐ No
Is this coverage intended to replace or change any life insurance or annuity contract in force with us or any other company?	☐ Yes ☐ No
Is the policy or contract you are replacing an existing life insurance or an annuity contract in force with SBLI?	☐ Yes ☐ No

For any "Yes" answers to above, please complete the state required replacement form and list below:

Insurance Company	Name of Insured	Face Amount	Replaced or Changed?
			☐ Yes ☐ No
			☐ Yes ☐ No

7. PAYING FOR YOUR POLICY

Full name and billing address (if different from the Owner)

Initial payment amount	Billing frequency

Please Choose a Billing Option

Your first payment is due with your signed application.

OR

Coincide with the Social Security Payment Schedule

☐ 1st of month ☐ 2nd Wednesday

☐ 3rd of month ☐ 3rd Wednesday

☐ 4th Wednesday

Your Policy Issue Date will be the date of your first payment.

Bank name	Bank routing number	Bank account number	
Credit card/Debit card number	**Visa, MasterCard or American Express**	**Expiration date**	**CVV**

Name of Proposed Insured:	SSN:	Date of Birth:

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 **X**	Date		
Signature of Owner/Applicant (*if not Proposed Insured*) **X**	Date	**Signature of Payor** (*if not Owner/Applicant*) **X**	Date
Signature of Producer **X**	Date	Producer #	License #
Producer Name Printed	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 Applicant.

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.*	☐ Yes ☐ No
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?	☐ Yes ☐ No

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	Producer Name Printed	Date

Lead #:
Source:
Rate Code:
Process Date:

Underwriting Stamp