[MassMutual]

Application for Term Life Insurance

[Offered exclusively through: HAVEN life Insurance Agency]

The Insurer identified below will be referred to herein as the "Company":

Massachusetts Mutual Life Insurance Company (MassMutual) [1295 State Street, Springfield, Massachusetts 01111-0001]

Unless subsidiary designated below:

☐ **C.M. Life Insurance Company [**100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981]

[Company Administrative Office: 100 Centerview Drive, Suite 100, Nashville, TN 37214]

*Use this form to apply for individual Convertible Term Life Insurance and Temporary Life Insurance Coverage [offered exclusively through Haven Life Insurance Agency, **LLC**. ("Haven Life"), a wholly owned subsidiary of **Massachusetts Mutual Life Insurance Company ("MassMutual")**. For additional information or questions about the application process, contact Haven Life at (855) 744-2836 or email help@havenlife.com]. "You" and "your" in sections A–H refer to the Proposed Insured.*

A Personal Information

1. Full legal name *(First, MI, Last, Suffix):* _____
2. Gender *(Select one):* ☐ Male ☐ Female
3. Date of birth *(mm/dd/yyyy):* _____
4. Place of birth *(Country & State/Province):* _____
5. Residential address – do not use PO Box *(Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):*

   _____

   _____
6. Mailing address – only if different than question 5 *(PO Box or Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):*

   _____

   _____
7. Phone number: (_____) _____ - _____ Extension: _____ ☐ Mobile ☐ Other
8. Email address: _____
9. Taxpayer Identification Number *(SSN/ITIN):* _____
10. U.S. Driver's License: ☐ Yes ☐ No If No *(Select one):* ☐ Passport ☐ State ID ☐ Other *(Specify):* _____
    a. Identification number: _____
    b. State or Country of issue: _____
    c. Expiration date *(mm/dd/yyyy):* _____ *Only required if Passport, State ID or Other*
11. Type of citizenship *(Select one):* ☐ Resident U.S. citizen ☐ Other *(Specify):* _____

B Personal History Information

Provide additional information in the Additional Details Supplement for any question answered Yes in this section.

1. Have you ever been convicted of a felony, or are you currently on parole or probation? ☐ Yes ☐ No
2. Have you been convicted of operating a motor vehicle while under the influence of alcohol or drugs within the last 5 years? ☐ Yes ☐ No
3. Have you been in a motor vehicle accident in which you were found to be at fault, convicted of a moving violation or received a driver's license restriction or revocation within the last 3 years? ☐ Yes ☐ No
4. Have you been convicted of driving with a suspended or revoked license within the last 5 years? ☐ Yes ☐ No
5. Is your license currently suspended? ☐ Yes ☐ No
6. Have you had military service deferment, rejection or discharge because of a physical or mental condition? ☐ Yes ☐ No
7. Are you currently disabled (unable to work, attend school or perform your normal activities) and/or applying for any disability benefits? ☐ Yes ☐ No
8. Current occupation: _____
   a. Job duties: _____
   b. Employer/business name *(If self-employed, provide business name):* _____

B Personal History Information *continued*

c. Employer/business address *(PO Box or Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):*

9. Income information.

If employed:		*If a student, retiree, homemaker, juvenile, unemployed or disabled:*	
Annual earned income:	$	Annual household earned income:	$
Annual unearned income:	$	Annual household unearned income:	$
Net worth:	$	Household net worth:	$

10. Do you anticipate any foreign travel in the next 2 years? *If Yes, use Foreign Travel Supplement.* ☐ Yes ☐ No

11. Do you have a written agreement to become, or are you currently a member of, the Armed Forces? *If Yes, use Military Supplement.* ☐ Yes ☐ No

12. Do you expect to become within the next 2 years, or have you been in the last 3 years, a pilot, a student pilot or crew member of any aircraft? *If Yes, use Aviation Supplement.* ☐ Yes ☐ No

13. Have you taken part in underwater diving, hang gliding, para sailing, para kiting, parachuting, skydiving, ultralight, soaring, ballooning, bungee jumping, rock or mountain climbing, helicopter skiing, professional martial arts, big game hunting, boxing or organized racing by automobile, motorcycle, motorboat, bobsled or snowmobile in the last 3 years or do you intend to in the next 2 years? *If Yes, use Avocation Supplement.* ☐ Yes ☐ No

C Medical Information

Provide additional information in the Additional Details Supplement for any question answered Yes in this section.

1. Current height *(Feet, inches):*

2. Current weight *(Pounds):*

3. Have you gained or lost more than ten (10) pounds in the last twelve (12) months? ☐ Yes ☐ No

a. If Yes, how much? ☐ Gain ☐ Loss

b. Due to *(Select all that apply):* ☐ Childbirth ☐ Diet ☐ Exercise ☐ Other *(Specify):*

4. Primary physician name/Practice name:

a. Business address *(Street, Suite #, City & State or Country, ZIP/Postal Code):*

b. Telephone:

c. Date last seen:

5. Family history. Provide information about your immediate biological family members (i.e. parents, siblings) below.

a.

Family Member	**Status** *(Select one)*	**Age at Death**	**Cause of Death**
Father	☐ Alive ☐ Deceased ☐ Unsure		
Mother	☐ Alive ☐ Deceased ☐ Unsure		
	☐ Alive ☐ Deceased ☐ Unsure		
	☐ Alive ☐ Deceased ☐ Unsure		

b. Have any of your immediate biological family members ever been diagnosed by a member of the medical profession with cancer, heart disease, diabetes or kidney disease? ☐ Yes ☐ No

c. Have any of your immediate biological family members ever been diagnosed by a member of the medical profession with Polycystic Kidney Disease, Huntington's Disease, Marfan Syndrome, Lynch Syndrome or Cardiomyopathy (heart disease)? ☐ Yes ☐ No

C Medical Information *continued*

6. Have you used tobacco or other nicotine containing products, including e-cigarettes and non-prescription smoking cessation aids (e.g. a patch or gum):

- **a.** Within the last 12 months? ☐ Yes ☐ No
- **b.** Within the last 24 months? ☐ Yes ☐ No
- **c.** More than 24 months ago? ☐ Yes ☐ No

7. Have you used a prescription medication to assist with smoking cessation or as a substitute for smoking (e.g. Chantix, Wellbutrin, etc.) within the last 12 months? ☐ Yes ☐ No

8. On average, do you consume more than 3 alcoholic drinks per day (one drink is approximately 12 ounces of beer, 5 ounces of wine or 1.5 ounces of spirits)? ☐ Yes ☐ No

9. Are you currently pregnant? ☐ Yes ☐ No

10. In the past 10 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder noted below:

- **a.** Chest pain, heart attack, high blood pressure, heart murmur, palpitations or any other disorder of the heart, arteries or veins? ☐ Yes ☐ No
- **b.** Elevated cholesterol or triglyceride levels (hyperlipidemia)? ☐ Yes ☐ No
- **c.** Any malignant tumor or cancer including skin cancer, leukemia or lymphoma? ☐ Yes ☐ No
- **d.** A disorder of the blood, spleen or immune system including anemia, blood clots, bleeding or immune deficiency? ☐ Yes ☐ No
- **e.** A disorder of the brain, spinal cord or nervous system including seizures, tremors, paralysis, dizziness, fainting, headaches, brain tumor, brain aneurysm or bleeding, stroke or TIA (transient ischemic attack)? ☐ Yes ☐ No
- **f.** Depression, anxiety, nervousness, stress, psychosis, suicide thoughts or attempts, anorexia or bulimia, post traumatic stress disorder, sleep disorder, obsessive compulsive disorder, bipolar disorder, attention deficit hyperactivity disorder (ADHD) or other emotional disorder? ☐ Yes ☐ No
- **g.** A disorder of the eyes, ears, nose, throat or sinuses including any partial or complete loss of hearing, vision or speech? ☐ Yes ☐ No
- **h.** Asthma, allergies, shortness of breath, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), pneumonia, sleep apnea, tuberculosis or any other disorder of the respiratory system? ☐ Yes ☐ No
- **i.** A disorder of the digestive system, liver, pancreas or gall bladder including hepatitis, jaundice, ulcers, intestinal bleeding, colitis, Crohn's disease (ileitis), polyps, recurrent indigestion, diarrhea or diverticulitis? ☐ Yes ☐ No
- **j.** A disorder or impairment of the muscles, bones, joints, nerves, spine, neck or back including arthritis, gout, sciatica or amputations? ☐ Yes ☐ No
- **k.** Epstein-Barr virus, Lyme disease, chronic fatigue syndrome, fibromyalgia, lupus or other rheumatologic disorder? ☐ Yes ☐ No
- **l.** Diabetes or a disorder of the thyroid, pituitary or adrenal glands? ☐ Yes ☐ No
- **m.** A disorder of the kidneys, bladder, prostate or urinary tract or findings of sugar, protein or blood in the urine? ☐ Yes ☐ No
- **n.** A disorder of the skin including eczema or psoriasis? ☐ Yes ☐ No
- **o.** A diagnosis of Human Immunodeficiency Virus (AIDS virus) infection or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
- **p.** A disorder of the uterus, cervix, ovaries or breasts? ☐ Yes ☐ No
- **q.** A complicated pregnancy? ☐ Yes ☐ No

11. In the last 10 years, have you:

- **a.** Used cocaine, barbiturates, amphetamines, heroin, narcotics, stimulants, hallucinogens or other controlled substances or habit forming drugs not prescribed by a physician? ☐ Yes ☐ No
- **b.** Received medical treatment, attended a program or been counseled for alcohol or drug abuse or been advised by a member of the medical profession to reduce the use of alcohol? ☐ Yes ☐ No
- **c.** Had any of the following medical procedures:
  - **i.** A blood transfusion? ☐ Yes ☐ No
  - **ii.** A surgical procedure involving your heart, arteries or veins, such as a stent implant, angioplasty, pacemaker implant or ablation? ☐ Yes ☐ No
  - **iii.** A mastectomy, prostatectomy or oopherectomy? ☐ Yes ☐ No

C Medical Information *continued*

12. In the last 5 years, have you:

a. Had an ECG (electrocardiogram)? ☐ Yes ☐ No

b. Had an application for life, disability or health insurance declined, postponed, rated or restricted? ☐ Yes ☐ No

c. Had a sickness or injury for which a disability claim was made or payments, benefits or pension benefits were received? ☐ Yes ☐ No

13. In the last 3 years, have you had a physical exam, check-up or evaluation by a member of the medical profession regarding a condition not previously stated on this Application? ☐ Yes ☐ No

14. Are you currently under treatment by a member of the medical profession for anything not previously stated on this Application? ☐ Yes ☐ No

15. Are you currently taking any prescription medications not previously stated on this Application (excluding contraceptives)? ☐ Yes ☐ No

D Product Information

1. Plan: _____

2. Face amount: $ _____

3. Waiver of Premium Rider: ☐ Yes ☐ No

E Purpose of Insurance

1. What is the purpose of the insurance? *(Select all that apply):* ☐ Protection for my family ☐ Other *(Specify):* _____

2. Will this policy be collaterally assigned? ☐ Yes ☐ No

3. Has the Proposed Insured(s) and/or the Proposed Policy Owner(s) been offered any economic incentive such as "free" life insurance or money to purchase this policy or entered into any arrangement that entitles a lender or investor to any portion of the death benefit beyond a loan repayment? ☐ Yes ☐ No

4. Does the Proposed Insured(s) and/or the Proposed Policy Owner(s) have a current agreement or commitment to sell, transfer, assign, or release this policy – or any beneficial interest of this policy or its ownership structure – to a life settlement company, viatical company, bank, investor or secondary market provider? ☐ Yes ☐ No

F Owner & Beneficiary Information

1. Owner(s) *(Select one):* ☐ Proposed Insured is the only Owner ☐ Other

If Other, use Owner Designation Form and provide Proposed Owner name(s): _____

2. Beneficiary *(Select one):* ☐ Sole Individual Primary/Sole Individual Secondary Beneficiary *(Complete table below)* ☐ Other

If Other, use Beneficiary Designation Form and skip to section G—Other Coverage/Replacement Information.

Primary. Full legal name: _____

Mailing address: _____

Phone number: (_____) _____ - _____ Ext: _____ ☐ Home ☐ Work ☐ Mobile ☐ Unknown

Date of birth *(mm/dd/yyyy):* _____ TIN: _____ ☐ SSN ☐ EIN ☐ Unknown

Relationship to Insured: _____ Distribution: 100%

Secondary. Full legal name: _____

Mailing address: _____

Phone number: (_____) _____ - _____ Ext: _____ ☐ Home ☐ Work ☐ Mobile ☐ Unknown

Date of birth *(mm/dd/yyyy):* _____ TIN: _____ ☐ SSN ☐ EIN ☐ Unknown

Relationship to Insured: _____ Distribution: 100%

G Other Coverage/Replacement Information

1. What is the total amount of life insurance currently **applied for** or contemplated with the Company or any other companies?

   $ _____

2. What is the total amount of life insurance currently **in force** on you with the Company or any other companies, including any policies which may have been sold, transferred or assigned?

   $ _____

3. Is this Application intended to replace or change any life insurance or annuity contract in force with the Company or any other companies?
   ☐ Yes ☐ No

4. Do you have existing life insurance or annuity contracts currently in force or applied for? ☐ Yes ☐ No

   If Yes, list all policies below, one per row.

Company	Policy Number *(If known)*	Face Amount	Product	Issue Yr.	Purpose	Status
		$			☐ Business ☐ Personal	☐ Applied for ☐ Inforce
		$			☐ Business ☐ Personal	☐ Applied for ☐ Inforce
		$			☐ Business ☐ Personal	☐ Applied for ☐ Inforce
		$			☐ Business ☐ Personal	☐ Applied for ☐ Inforce
		$			☐ Business ☐ Personal	☐ Applied for ☐ Inforce
		$			☐ Business ☐ Personal	☐ Applied for ☐ Inforce

H Payment Information

1. Source of premium *(Select all that apply):* ☐ Income, investments, savings, gifts and/or inheritance ☐ Other: _____

2. Premium Payor *(Select one):* ☐ Proposed Insured(s) ☐ Proposed Owner(s) ☐ Other

   If Other is selected, provide details in questions 2a and 2b. Otherwise, skip to section I—Disclosures.

   a. Full legal name *(First, MI, Last, Suffix):* _____

   b. Mailing address *(PO Box or Street, Apt. or Suite #, City & State or Country, ZIP/Postal Code):*

   _____

   _____

I Disclosures

The Application. This Application will be attached to and made a part of the insurance policy for which the Proposed Insured and the Proposed Owner (if different) are applying. This is part of an Application for Life Insurance. The Application may include statements and supplements.

Life Insurance Coverage. Insurance coverage under the Policy takes effect on the later of the date the Policy is issued or the first premium payment is received, provided that the Proposed Insured is alive. Failure to satisfy all of these requirements will result in no insurance coverage taking effect.

Charges. If a life insurance policy is issued, insurance coverage will begin as defined in the Life Insurance Coverage section. Policy charges will begin on the Policy Date, which is defined in the Policy.

General Provisions:

- **Owner:** This Application assumes that the Insured is Owner unless otherwise designated.
- **Beneficiary:** Proceeds shall be paid in one sum. If there is no living or existing Beneficiary, the proceeds will be paid to the Owner or the Owner's estate.

J Agreements & Signatures

Electronic Signature Use. "You" and "your" in this paragraph refer to the Proposed Owner under this Application. Your consent to the use of electronic processing allows the Company to accept an electronic signature from you. This electronic signature will have the same effect as a physical wet signature associated with paper applications and will appear on all Company records related to the purchase of this Policy. Your consent also permits the general use of electronic records and electronic signatures in connection with your Application and Policy applied for. The Company is legally required to provide you with certain disclosures and information about your insurance Application ("Required Information"). By giving your consent, the Company can deliver this Required Information to you electronically. You may change your mind and withdraw your consent for electronic delivery or e-signature at any time. If you withdraw your consent prior to electronic delivery of the Policy, the Company cannot continue to process your Application. Your consent applies to all Required Information that the Company gives you, or information that the Company receives from you, about your insurance Application and the notices, disclosures, and other documents. To withdraw your consent to do business electronically, send a written notice by e-mail or U.S. Mail to our administrative office. In the event that your consent is withdrawn, you may be charged for paper copies for any information you request.

Acknowledgment of Electronic Receipt of the Company Notices and Disclosures. In connection with this Application, the Company's notices about MIB Group, Inc (formerly known as the Medical Information Bureau), the Fair Credit Reporting Act, the Company's privacy practices, a description of the underwriting process, a description of software and hardware necessary to accept electronic delivery and all Required Information have been provided and received electronically by the Proposed Insured and Proposed Owner (if different).

Authorization to Obtain and Disclose Information. I, the Proposed Insured, authorize the Company to review this Application and the information contained therein and to collect and review such other information as it deems necessary, including such medical and non-medical information as the Company may request. I hereby authorize certain parties that have records or knowledge of me and/or my health to make such information available to the Company, its reinsurers, its affiliated insurance companies, its agents, employees, and representatives. These parties shall include any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, the MIB, pharmacy data search companies, Department of Motor Vehicles, consumer reporting agency, current or former employer, insurance company, and other organizations having information relevant to the issuance or administration of this policy. I further authorize the Company to obtain and conduct a personal history information interview and/or a written inspection in connection with this Application and authorize the Company to obtain an investigative report regarding information about my character, general reputation, personal characteristics and mode of living. I understand that any and all such information obtained by the Company through such interviews, inspections, or reports may be made available to the Company's agents, employees and representatives for determining eligibility for insurance, reinsurance, reinstatement requests, or changes in benefits. I also authorize the Company, or its reinsurers, to disclose personal health information about me to the MIB in the form of a brief coded report for participation in MIB's fraud prevention and detection programs. This authorization shall be valid for 24 months from the date of my signature on this Application which complies with the time limit, if any, permitted by applicable law in the state where a policy would be delivered or issued for delivery. All documents and information submitted to, or acquired by, the Company become property of the Company. A photocopy facsimile or electronic copy of this authorization may be relied upon as if it were an original. I understand I have the right to revoke this authorization at any time and that my revocation will not apply to any information shared in reliance on this authorization prior to my revocation.

Taxpayer Identification

*If the Proposed **Insured will be the Proposed Owner, the Proposed Insured must complete this Taxpayer Identification section. If the Proposed Insured will not be the Proposed Owner, do not complete this section as information will be captured on the Owner Designation Form.***

By my signature, I, the Proposed Insured/Owner, certify under penalties of perjury, that:

a. The number shown in Section A (question 9) is my correct Taxpayer Identification Number: ☐ Yes ☐ No

b. I am NOT subject to backup withholding: ☐ Yes ☐ No

c. I am a U.S. person (including a U.S. resident alien): ☐ Yes ☐ No

d. The FATCA exemption code entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. . . . . Not Applicable
Note: While the Company is required by the IRS to include this certification, FATCA does not apply to a U.S. account owned by a U.S. person, so the Company has not included the ability to enter an exemption code. If the Proposed Insured/Owner has indicated that he/she is not a U.S. person, any applicable FATCA information will be captured on the W-8 form.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

J Agreements & Signatures *continued*

Signatures

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.

I, the undersigned Proposed Insured (and Proposed Owner, if different), have read the Application including all supplements, all statements and answers, and each of the pages to be e-signed, and affirm that these statements and answers are true, complete, and correctly recorded to the best of my/our knowledge and belief. I/We hereby adopt all statements made in the Application and agree to be bound by them. I/We hereby give consent to electronic processing. I/We understand that the Application and Temporary Life Insurance Coverage form (if applicable) are being electronically signed and that the electronic signature is a valid and binding signature.

Signature of Proposed Insured: _____

Printed name: _____ Date: _____

Signature of Policy Owner *(If other than Proposed Insured):* _____

Printed name: _____ Date: _____