Application for Individual Term Life Insurance
Massachusetts Mutual Life Insurance Company

[$500,000 of coverage]
[20 year Haven Term policy]

Home Office: Springfield, MA
Administrative Office: [100 Centerville Drive, Suite 100, Nashville, TN 37214]

My name is — First | Middle | Last

I identify as — Male | Female

My birthday is

I was born in — Select country

I am a U.S. citizen and resident — Yes | No

My occupation is

☐ I am unemployed

My annual income is

My biological parents or biological siblings have been diagnosed by a member of the medical profession with any of the following: cancer, heart disease, diabetes, kidney disease, Huntington's Disease, Marfan Syndrome, or Lynch Syndrome. — Yes | No | Not Sure

My height is ____ feet ____ inches

My weight is currently ____ pounds

☐ It has changed more than 10 lbs in the past year

In a week, I typically drink ____ alcoholic beverages

The last time I used tobacco, other nicotine-containing products or e-cigarettes was — ◯ ____ years ago ◯ Within the last year ◯ Never

Within the next 2 years, do you expect to travel outside the U.S.? — Yes | No | Not Sure

Have you participated in the past 3 years or will you participate in the next 2 years in any of the following:

☐ **Airborne Sports**: hang gliding, parachuting, skydiving, ultralight, soaring, ballooning, or bungee jumping

☐ **Mountain Sports**: rock or mountain climbing, or heli skiing

☐ **Organized Racing:** automobile, motorcycle, motorboat, snowmobile, luge, skeleton or bobsledding

☐ **Martial Arts**: boxing, mixed martial arts, or professional martial arts

☐ **Aviation**: being a pilot, student pilot or crew member of any aircraft, including a private plane

☐ **Other**: scuba diving or big game hunting

☐ **None of the above**

In the past 5 years, have you been disabled (unable to work, attend school, or perform your normal activities) or have you applied for or received disability benefits or workers' compensation? — Yes | No

In the past 10 years, have you been advised by a member of the medical profession that you have:

- High blood pressure — Yes | No
- High cholesterol — Yes | No

In the past 10 years, have you:

☐ Used any habit forming drugs or controlled substances not prescribed by a physician?

☐ Been hospitalized or held overnight for an emotional or mental disorder, or for any reason other than childbirth?

☐ Received treatment, attended a program, or been counseled to reduce the use of alcohol?

☐ Been diagnosed by a member of the medical profession with cancer or diabetes?

☐ Been diagnosed by a member of the medical profession with any disease or disorder of the heart, blood or blood vessels, lungs, liver, kidneys, thyroid, bones, joints, or the immune, neurological or gastrointestinal system?

☐ None of the above

In the past 5 years, has a member of the medical profession advised you to have an urgent treatment, procedure, or test (excluding tests related to Human Immunodeficiency Virus/AIDS Virus) that has not yet been completed? — Yes | No

Has a member of the medical profession diagnosed you with the Human Immunodeficiency Virus (HIV/AIDS Virus)? — Yes | No

Will you be the insured as well as the policy owner and the person responsible for paying the monthly premiums? (The owner and/or payor of the policy can be changed at a later date.) — Yes | No

The current amount of total life insurance or annuity contracts I have or that I am applying for with other companies (not including any coverage through my employer is)

I live at
Line 1
Line 2
Zip | City | State

My driver's license number is

The issuing state is

It expires on

☐ I don't have a driver's license

In the past 5 years, I have been charged with a major moving violation, found to be at fault for a motor vehicle accident or had my license suspended and/or revoked. — Yes | No

In the past 5 years, I have been convicted of operating a motor vehicle while under the influence of alcohol or drugs. — Yes | No

My Social Security Number or Taxpayer ID is

My phone number is

Do any of the following apply to you:

- Are you on active military duty and/or do you have a written agreement to enlist? — Yes | No
- Are you applying for insurance for investment or business purposes? — Yes | No
- Do you intend to use this policy as collateral or intend to convert ownership of this policy to a lender or investor? — Yes | No
- Have you ever been convicted of a felony, or are you currently on parole or probation? — Yes | No

Type of beneficiary

Agreements, Disclosures & Signatures

The Application. This Application will be attached to and made a part of the insurance policy for which the proposed person being insured ("Insured") and the proposed owner of this policy ("Owner"), if different, are applying. This is part of an Application for Life Insurance.

Life Insurance Coverage. Insurance coverage under the Policy takes effect on the later of the Policy Date or when 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. The Policy Date may occur before insurance under this Policy takes effect in cases where the initial premium payment is unsuccessful or the Policy coverage is backdated to save age. If so, you will be charged premiums during the period in which no insurance was in force.

General Provisions - Beneficiary. Proceeds shall be paid in one sum equally across all designated beneficiaries. If a designated beneficiary is deceased, their benefit will be equally distributed among their descendants. In the event that there are no descendants, the benefit will be equally distributed among the other beneficiaries who are listed on the policy and still alive. If there is no living or existing Beneficiary, the proceeds will be paid to the Owner or the Owner's estate.

General Provisions - Owner. This Application assumes that the Insured is the Owner unless otherwise designated.

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 of proposed Insured to Obtain and Disclose Information. I authorize 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 or agencies, 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 I may obtain information about the nature and scope of that investigative report from the Company. I further understand that certain nonmedical information such as credit history (e.g., payment history, collections and available credit limits) and public records (e.g. criminal history, bankruptcies, liens, professional licenses, home ownership) may be collected and reviewed to help determine my eligibility for Company's accelerated underwriting program. I agree that any and all such information obtained by the Company pursuant to this authorization may be made available to the Company's agents, employees and representatives for determining eligibility for insurance, reinsurance, reinstatement requests, changes in benefits, or for underwriting and actuarial research purposes.

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. I understand I have the right to revoke this authorization at any time by notifying the Company in writing. My revocation will not apply to any information used or disclosed prior to my revocation. 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.

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 the BASICS section of the Application 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.

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: _____ Date: _____

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