MassMutual
FINANCIAL GROUP
THE BLUE CHIP COMPANIES℠

Life and Disability

Survey (A3050)

This survey should be completed if:
- *there is any doubt that the Proposed Insured is insurable*
- *there is a question as to the insurability at standard rates*
- *another company has declined, rated, or limited insurance within the last 10 years.*

Contents

See additional information on reverse side

There is a direct relationship between providing complete and accurate medical history and facilitating underwriting so that clients receive the best possible service.

When You Should Use A Survey

A preliminary Survey Form should be submitted if any doubt exists regarding the insurability of the Proposed Insured or if the risk has been declined, rated, or limited by this or any other company within five years; except that a formal application may be submitted if the agent is certain that a policy written at the latest classification will be acceptable to the Proposed Insured.

General Instructions

- Answer each question completely.
  - — Assure that all required questions are answered. Don't skip any "yes / no" questions.
  - — Fully describe all medical history and findings. A history should be described thoroughly but concisely so that the "who, what, when and why" are clear to the reader.
  - — When the Proposed Insured or applicant is unclear as to the specifics of the medical history, try to include as much information as possible; particularly as to the relevant dates, names and addresses of physicians, hospitals, etc.
  - — In "Explanatory Details and Remarks" reference to the precise "Question Number" is important. For example, if reference is to a question with more than one part, do not enter the Question Number as "5", use "5c" even though it may seem obvious which part of the question is being referenced.
- Assure that all necessary signatures have been obtained on the authorization (Proposed Insured, witness, applicant) and the tear-off portion of the N148 has been given to the Proposed Insured or applicant.

SURVEY

To: Massachusetts Mutual Life Insurance Co. Springfield, Massachusetts 01111-0001

Client Data

1. **Client ID** (if known):
2. **Proposed Insured's Name:** (hereinafter referred to as the Insured) first name | middle name | last name | suffix (e.g. Jr., III)
3. **Current Address:** street & no. | city | state | zip
4. **Soc. Sec. No.:**
5. ☐ **Male** ☐ **Female**
6. **Birthplace:** _____
7. **Date of Birth:** mo. day yr.
8. **Citizenship, if not USA:** _____ **Type of Visa** ☐ **Perm.** ☐ **Temp.**
9. What is his/her Occupation(s) and Exact Duties?
   Occupation(s) | Exact Duties

Product Data

10. (a) Life Insurance:

- ☐ Whole Life
- ☐ Limited Pay WL_____
- ☐ Enhanced Whole LIfe
- ☐ APT
- ☐ Variable Life Plus
- ☐ Universal Life
- ☐ _____

(b) Amount of Insurance:
Face Amount: $ _____

(c) Riders (list all rider names and amounts):

11. (a) Disability and BOE Insurance:

- ☐ Disability Income (DI or TD) ☐ Business Overhead Expense
- ☐ Conditionally Renewable Disability Income (CR or TCR)
- ☐ _____

(b) Amount of Insurance:
Monthly Income or Expense Amount: $_____

(c) Occupation Class (for occupation give in 9):
☐ 5A ☐ 4A ☐ 3A ☐ 2A ☐ A ☐ _____

(d) Waiting (Elimination) Period (days):
☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730 ☐ _____

(e) Maximum Benefit Period:
Years: ☐ to 1 yr. ☐ 2 ☐ 5 ☐ to age 65 ☐ ADEA
☐ Extended Monthly Income ☐ _____

(f) Riders (list all rider names and amounts):

Authorization to Massachusetts Mutual Life Insurance Company, Springfield, Massachusetts 01111-0001

I have received the Notice about the Medical Information Bureau, Inc. (MIB). I have also received the Notice about the Fair Credit Reporting Act. I understand and authorize an investigative report to be made. This report may include information about my character, general reputation, personal characteristics and mode of living. I hereby authorize certain parties that have any records or knowledge of me and my health (or my children and their health if juvenile insurance), to make such information available to the Massachusetts Mutual Life Insurance Company or its reinsurers. These parties include: any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, the MIB, or other organization. I also authorize MassMutual, or its reinsurers, to disclose information about me to the MIB in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

Witness	Proposed Insured	Date
Witness	Applicant (if survey is for Juvenile Insurance)	Date

Personal Information

12. Reason Survey being being submitted: _____

13. Insured's Income:

Annual Earned Income $ _____ Annual Unearned Income $ _____

14. Is there now, or has the Insured had, any illness, sickness, injury or impairment of health? ..... **Yes** ☐ **No** ☐

(If "Yes", complete below for each illness, injury or impairment of health.)

A.	Diagnosis	Medication/Treatment	Still Under Treatment ☐ Yes ☐ No	# of Attacks/ Occurrences	Dates (mo/yr) Onset	Recovery

Physician/Medical Facility Name	Address	Zip

B.	Diagnosis	Medication/Treatment	Still Under Treatment ☐ Yes ☐ No	# of Attacks/ Occurrences	Dates (mo/yr) Onset	Recovery

Physician/Medical Facility Name	Address	Zip

15. a. Height in shoes _____ ft. _____ inches
b. Weight (clothed) _____ lbs.
c. Loss in weight in the last 12 months ☐ Yes ☐ No
If "Yes", Amount _____ lbs. Reason _____

16. Family History	Age if Living	Age at Death	Cause of Death
a. Father			
b. Mother			

If "Yes" to any questions, please explain in 20 below. **Yes** **No**

17. Have any of his/her parents, brothers or sisters:
(a) had cardiovascular disease prior to age 60? ..... ☐ ☐
(b) ever had diabetes, kidney disease, or other familial disorder? ..... ☐ ☐

18. Has he/she smoked cigarettes in the last 12 months? ..... ☐ ☐

19. Has he/she applied for life or health insurance and been declined, postponed, rated or restricted in the last ten years? ..... ☐ ☐

20. Question Number | Explanatory Details and Remarks

Question Number	Explanatory Details and Remarks

21. Within the last 3 years has he/she been or does he/she now expect to become, a pilot, student pilot or crew member of any type of aircraft? **If "Yes", complete Aviation Supplement A3310** ..... ☐ ☐

22. Within the last 3 years has he/she or does he/she now expect to take part in underwater diving, hang gliding, para sailing, para kiting, parachuting, skydiving, mountain climbing or organized racing by automobile, motorcycle, motorboat or snowmobile? **If "Yes", complete Avocation Supplement A3320** ..... ☐ ☐

Date (month day year) _____ Agency Name _____ Agency No. _____ Soliciting Agent _____

MassMutual FINANCIAL GROUP®

Massachusetts Mutual Life Insurance Company
1295 State Street, Springfield, MA 01111-0001

HIPAA Authorization

For use with Life, DI and Life with Long Term Care Riders

This Authorization complies with HIPAA Privacy Rule.
"HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended.

A Authorizations

- I hereby authorize the use and disclosure of my medical records, medical history and other information that relates to the diagnosis, treatment or prognosis of any physical or mental condition, whether in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions**;** prescription drugs and pharmaceutical records; diagnostic testing; laboratory records; alcohol or drug use; and communicable or infectious diseases or conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases unless otherwise restricted by state law.
- This Authorization specifically excludes psychotherapy notes. Psychotherapy notes means notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session, and that are separated from the rest of any individual's medical record. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop dates, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date; therefore, such medical records are covered by this Authorization.
- I hereby authorize the following persons or entities who have provided payment, treatment or services to me or on my behalf within the past ten (10) years to disclose all medical or health information about me: a physician; medical practitioner or health care professional or provider; hospital; clinic; laboratory; medical or medically-related facility; pharmacy or pharmacy benefit manager; health plan. I further authorize the following persons or entities to disclose all medical or health information about me: any insurance company, including the Company (**"**Company" as referred to herein, is Massachusetts Mutual Life Insurance Company, and/or MML Bay State Life Insurance Company and/or C.M. Life Insurance Company), or reinsurance company; any consumer reporting agency such as the MIB, Inc. ("MIB"); the Department of Motor Vehicles or any other state or federal government agency; and/or any other organization, institution or person having personal health information about me.
- I hereby authorize the disclosure of my medical or health information to the Company, its service providers, its reinsurers and its agents, representatives and insurance producers (including the agents, representatives and employees of such persons or entities). I hereby authorize the disclosure of my medical or health information to any consumer reporting agency, including the MIB.
- I hereby authorize the use and disclosure of my medical or health information for purposes of and in connection with underwriting my application for insurance with the Company, determining the premium for the insurance, obtaining reinsurance, servicing my insurance and administering coverage, evaluating any claim for insurance benefits and conducting other legally permissible activities that relate to any coverage I have applied for. I understand that there may be additional uses or disclosures of my medical or health information that are specifically permitted by law without my Authorization, such as to government regulatory or law enforcement entities.

B Agreements, Understandings & Signatures

If I do not sign this Authorization, the Company may (i) decline my application for insurance or not be able to offer me any coverage and/or (ii) decline to pay a claim for benefits under any insurance issued. Providers of health care services or medical treatment may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.

- My Authorization may be revoked by sending a written request to:
  MassMutual, Attn: Authorization Administrator – Underwriting Department, 1295 State Street, Springfield, MA 01111-0001.
  I may not revoke any Authorization that was obtained as a condition of obtaining insurance, paying a claim, or that was relied or acted upon.
- This Authorization applies to my entire medical record. Any agreements I have made to restrict my medical or health information do not apply to this Authorization.
- My health information may be re-disclosed and no longer protected by HIPAA if the person receiving this information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers providing long-term care insurance and health care providers. However, the Company requires its employees, agents, representatives, insurance producers and service providers to protect the confidentiality of health information regardless of whether the employee, agent, representative, insurance producer or service provider is engaged in an insurance business subject to HIPAA. Information may only be re-disclosed in accordance with applicable laws or regulations.
- A copy or facsimile of this Authorization is valid as the original.
- This authorization is valid for twenty-four (24) months from the date I sign it.
- I have received a copy of this Authorization.

Some states' rules concerning Authorizations change the terms and provisions of this Authorization. By signing below, you acknowledge the conditions identified on page three are considered part of this Authorization and apply in the identified states.

Signature of Insured/Representative: _____

Printed name: _____ Date: _____

Date of birth *(mm/dd/yyyy):* ___/___/_____

Relationship to Insured *(If Representative):* _____

C State-Specific Authorizations

If you reside in a state listed below, then the identified provisions apply to your Authorization.

ARIZONA. With respect to disclosure of HIV-related information only, this Authorization is valid for 180-days from the date it is signed.

MAINE. This Authorization excludes the disclosure of the result of a test for HIV if the Insured has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat shall otherwise prohibit this Authorization from including other facts and information relative to the fact that the Insured has AIDS.

MINNESOTA. This Authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency personnel who were tested as a result of performing emergency medical services. The term "**emergency medical personnel**" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.

NEW MEXICO. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. During the time this Authorization is valid it extends to the information required to determine eligibility for benefits under any policy issued as a result of this application.

With respect to confidential abuse information, this Authorization may be revoked in writing, ten days after receipt by the Company, but doing so may result in an application or claim being denied or may otherwise adversely affect a pending insurance action.

The Company may collect genetic information about you for use in conducting and administering its business of insurance. "Genetic information" means the information about a genetic makeup of a person or members of a person's family, including information resulting from genetic testing, genetic analysis, DNA composition, participation in genetic research or use of genetic services. This information may only be used, transmitted or retained for the purpose of conducting and administering its business of insurance, except with your consent or as otherwise authorized or required by law.

OREGON. With respect to disclosure of HIV-related information only, this Authorization is valid for 180-days from the date it is signed.

VERMONT. This Authorization does not extend to previously administered test for HIV anitbodies, T-Cell counts, AIDS or ARC, nor to any medical doctor, doctor of osteopathy, physician, health care professional, hospital, clinic, medical facility, the Veterans Administration, the MIB Inc., employer, consumer reporting agencies, other insurance company, or anyone else, with respect to previous test results. I am not providing authorization for the release of results from any new test for the HIV virus to any outside, non-affiliated company nor to any company not under contract with the company to perform underwriting services.

VIRGINIA. If this Authorization is used for claim purposes it is valid for the duration of the claim.

This Authorization complies with HIPAA Privacy Rule.
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A Authorizations

- I hereby authorize the use and disclosure of my medical records, medical history and other information that relates to the diagnosis, treatment or prognosis of any physical or mental condition, whether in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions**;** prescription drugs and pharmaceutical records; diagnostic testing; laboratory records; alcohol or drug use; and communicable or infectious diseases or conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases unless otherwise restricted by state law.
- This Authorization specifically excludes psychotherapy notes. Psychotherapy notes means notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session, and that are separated from the rest of any individual's medical record. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop dates, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date; therefore, such medical records are covered by this Authorization.
- I hereby authorize the following persons or entities who have provided payment, treatment or services to me or on my behalf within the past ten (10) years to disclose all medical or health information about me: a physician; medical practitioner or health care professional or provider; hospital; clinic; laboratory; medical or medically-related facility; pharmacy or pharmacy benefit manager; health plan. I further authorize the following persons or entities to disclose all medical or health information about me: any insurance company, including the Company (**"**Company" as referred to herein, is Massachusetts Mutual Life Insurance Company, and/or MML Bay State Life Insurance Company and/or C.M. Life Insurance Company), or reinsurance company; any consumer reporting agency such as the MIB, Inc. ("MIB"); the Department of Motor Vehicles or any other state or federal government agency; and/or any other organization, institution or person having personal health information about me.
- I hereby authorize the disclosure of my medical or health information to the Company, its service providers, its reinsurers and its agents, representatives and insurance producers (including the agents, representatives and employees of such persons or entities). I hereby authorize the disclosure of my medical or health information to any consumer reporting agency, including the MIB.
- I hereby authorize the use and disclosure of my medical or health information for purposes of and in connection with underwriting my application for insurance with the Company, determining the premium for the insurance, obtaining reinsurance, servicing my insurance and administering coverage, evaluating any claim for insurance benefits and conducting other legally permissible activities that relate to any coverage I have applied for. I understand that there may be additional uses or disclosures of my medical or health information that are specifically permitted by law without my Authorization, such as to government regulatory or law enforcement entities.

B Agreements, Understandings and Signatures

If I do not sign this Authorization, the Company may (i) decline my application for insurance or not be able to offer me any coverage and/or (ii) decline to pay a claim for benefits under any insurance issued. Providers of health care services or medical treatment may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.

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- This Authorization applies to my entire medical record. Any agreements I have made to restrict my medical or health information do not apply to this Authorization.
- My health information may be re-disclosed and no longer protected by HIPAA if the person receiving this information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers providing long-term care insurance and health care providers. However, the Company requires its employees, agents, representatives, insurance producers and service providers to protect the confidentiality of health information regardless of whether the employee, agent, representative, insurance producer or service provider is engaged in an insurance business subject to HIPAA. Information may only be re-disclosed in accordance with applicable laws or regulations.
- A copy or facsimile of this Authorization is valid as the original.
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Printed name: _____ Date: _____

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MINNESOTA. This Authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency personnel who were tested as a result of performing emergency medical services. The term "**emergency medical personnel**" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.

NEW MEXICO. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. During the time this Authorization is valid it extends to the information required to determine eligibility for benefits under any policy issued as a result of this application.

With respect to confidential abuse information, this Authorization may be revoked in writing, ten days after receipt by the Company, but doing so may result in an application or claim being denied or may otherwise adversely affect a pending insurance action.

The Company may collect genetic information about you for use in conducting and administering its business of insurance. "Genetic information" means the information about a genetic makeup of a person or members of a person's family, including information resulting from genetic testing, genetic analysis, DNA composition, participation in genetic research or use of genetic services. This information may only be used, transmitted or retained for the purpose of conducting and administering its business of insurance, except with your consent or as otherwise authorized or required by law.

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VERMONT. This Authorization does not extend to previously administered test for HIV anitbodies, T-Cell counts, AIDS or ARC, nor to any medical doctor, doctor of osteopathy, physician, health care professional, hospital, clinic, medical facility, the Veterans Administration, the MIB Inc., employer, consumer reporting agencies, other insurance company, or anyone else, with respect to previous test results. I am not providing authorization for the release of results from any new test for the HIV virus to any outside, non-affiliated company nor to any company not under contract with the company to perform underwriting services.

VIRGINIA. If this Authorization is used for claim purposes it is valid for the duration of the claim.

Notice To Insured And/Or Applicant For Insurance

Thank you for applying for insurance with us. We will give your application prompt consideration and will notify you of our action as soon as possible.

In addition to your answers on the application, we must also consider information from other sources. These sources may include results of a physical examination, an investigative consumer report, and reports from doctors who have attended you or from hospitals where you have been treated.

MEDICAL INFORMATION BUREAU NOTICE - Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply that company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Unless the Medical Director feels that it is in your best interest to disclose this information to your physician, it will be disclosed directly to you. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. We or our reinsurers may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

The purpose of the Bureau is to protect its member companies and their policyholders from the costs created by people who try to hide facts about their insurability. Information furnished by the Bureau cannot be used as a basis for evaluating risks. However it may be used to alert us to the possible need for further investigation. THE BUREAU DOES NOT HAVE MEDICAL REPORTS FROM HOSPITALS AND DOCTORS. THE INFORMATION IN ITS FILES DOES NOT SHOW WHETHER AN INSURANCE APPLICATION WAS ACCEPTED, PLACED IN AN INCREASED PREMIUM CLASS OR DECLINED.
(This Notice is only valid where permitted by law).

FAIR CREDIT REPORTING ACT NOTICE - As previously noted, an investigative consumer report may be made on you. It will cover information about your insurability, including information regarding your character, general reputation, personal characteristics and mode of living. The information may be obtained through personal interviews with you, an adult family member, friends, neighbors and associates. You may send us a written request for a complete and accurate disclosure of the nature and scope of any report that is made.

If requested, we will be happy to let you know whether or not we asked for an investigative consumer report to be made. If we did, we will also tell you the name and address of the consumer reporting agency that furnished the report. By contacting that agency, you may inspect and receive a copy of the report.

OUR PURPOSE - Part of our basic Company purpose is to provide insurance at the lowest possible cost. The underwriting process is necessary both to assure this low cost and to make sure that each policyholder contributes his or her fair share of the cost. The procedures described above benefit you as a policyholder, because they assist us in providing your insurance at the lowest possible cost.