

<i>SERFF Tracking Number:</i>	<i>SBMS-125795100</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>SBLI of MA</i>	<i>State Tracking Number:</i>	<i>40288</i>
<i>Company Tracking Number:</i>	<i>2008003AAR</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Applications for Life Insurance</i>		
<i>Project Name/Number:</i>	<i>/2008003</i>		

Filing at a Glance

Company: SBLI of MA

Product Name: Applications for Life Insurance	SERFF Tr Num: SBMS-125795100	State: ArkansasLH
TOI: L071 Individual Life - Whole	SERFF Status: Closed	State Tr Num: 40288
Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: 2008003AAR	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: James Coady, James MacDougall, Jason Brush, Dwight Wilbur, Janice Albertazzi	Disposition Date: 10/03/2008
	Date Submitted: 09/17/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number: 2008003	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/03/2008	
State Status Changed: 10/03/2008	Deemer Date:
Corresponding Filing Tracking Number:	
Filing Description:	
Applications for Life Insurance and additional supplements and amendment forms:	

The submission consists of three primary forms: "Application for Insurance Part 1" (Form A-91), "Application for Insurance Part 2" (Form A-92) and "Conditional Receipt Agreement" Form A-90) and a set of supplemental amendment

SERFF Tracking Number: SBMS-125795100 State: Arkansas
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TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Applications for Life Insurance
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forms that may be generated to obtain additional information in connection with specific responses that may be entered on the primary application forms.

All forms are listed individually within the Form Schedule Tab, completed in "John Doe" format.

These applications and supplemental forms will be used with the following policies that have been submitted to your Department this same date under separate cover.

Policy Number Title

B-40.6 Whole Life Insurance Policy

B-43.4 YRT Policy

B-46.1 Level Term Policy

Company and Contact

Filing Contact Information

James Coady, Jcoady@SBLI.com
1 Linscott Road (781) 994-5410 [Phone]
Woburn, MA 01801 (781) 994-4124[FAX]

Filing Company Information

SBLI of MA CoCode: 70435 State of Domicile: Massachusetts
1 Linscott Road Group Code: 4553 Company Type: Life
Woburn, MA 01801 Group Name: State ID Number:
(781) 938-3500 ext. [Phone] FEIN Number: 04-3117253

Filing Fees

Fee Required? Yes

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Product Name: Applications for Life Insurance
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Fee Amount: \$225.00
Retaliatory? Yes
Fee Explanation: Fee Calculation Explanation : Domicile State Fee = \$75.00
Three Base Application Forms: 3 X \$75.00 = \$225.00
Per Company: No

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CHECK NUMBER	CHECK AMOUNT	CHECK DATE
67349	\$225.00	09/10/2008

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/03/2008	10/03/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	10/01/2008	10/01/2008	James Coady	10/01/2008	10/01/2008

SERFF Tracking Number: SBMS-125795100

State: Arkansas

Filing Company: SBLI of MA

State Tracking Number: 40288

Company Tracking Number: 2008003AAR

TOI: L071 Individual Life - Whole

Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single
Life

Product Name: Applications for Life Insurance

Project Name/Number: /2008003

Disposition

Disposition Date: 10/03/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SBMS-125795100 State: Arkansas
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 Company Tracking Number: 2008003AAR
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Applications for Life Insurance
 Project Name/Number: /2008003

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Form (revised)	Life Insurance Application – Part 1		Yes
Form	Life Insurance Application – Part 1	Withdrawn	Yes
Form	Life Insurance Application – Part 2		Yes
Form	Conditional Receipt Agreement		Yes
Form	Supplement to Life Insurance Application – Part 1		Yes
Form	Supplement to Life Insurance Application – Part 2		Yes
Form	Supplement to Life Insurance Application		Yes
Form	General Aviation Questionnaire		Yes
Form	Commercial Aviation Questionnaire		Yes
Form	Alcohol Questionnaire		Yes
Form	Allergies Questionnaire		Yes
Form	Asthma Questionnaire		Yes
Form	Chest Pain Questionnaire		Yes
Form	Diabetes Questionnaire		Yes
Form	General Medical Questionnaire		Yes
Form	Kidney Stones Questionnaire		Yes
Form	Mental Health Questionnaire		Yes
Form	Seizures Questionnaire		Yes
Form	Colitis Questionnaire		Yes
Form	Drugs Questionnaire		Yes
Form	DUI Questionnaire		Yes
Form	Skin and SCUBA and Submersible Diving Questionnaire		Yes
Form	Substance Abuse Questionnaire		Yes
Form	Military Status Questionnaire		Yes
Form	Military Aviation Questionnaire		Yes

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 Product Name: Applications for Life Insurance
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Form	Avocation and Professional Sports Questionnaire	Yes
Form	Hang Gliding Questionnaire	Yes
Form	Motor Sports Questionnaire	Yes
Form	Power and Motor Boat Questionnaire	Yes
Form	Unemployment Questionnaire	Yes
Form	Citizenship Questionnaire	Yes
Form	General Amendment	Yes
Form	Updated Health Amendment	Yes
Form	Agents Replacement Certification	Yes
Form	Children under UTMA as Beneficiary	Yes
Form	Spouse, then Children under UTMA as Beneficiary	Yes
Form	Owner/Beneficiary	Yes
Form	Trust, then Estate as Beneficiary	Yes
Form	Trust as Owner	Yes
Form	Trust as Beneficiary and Owner	Yes
Form	Financial Disclosure Amendment	Yes
Form	Nicotine Amendment	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/01/2008
Submitted Date 10/01/2008

Respond By Date

Dear James Coady,

This will acknowledge receipt of the captioned filing.

Objection 1

- Life Insurance Application – Part 1 (Form)

Comment: We did not find a Fraud Statement for Arkansas as referenced in Ark. Code Ann. 23-66-503(a).

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/01/2008
Submitted Date 10/01/2008

Dear Linda Bird,

Comments:

Response 1

Comments: A revised Application Part 1, form # A-91AR, has been produced for use within Arkansas. The revised form contains the appropriate fraud warning in section L and has been attached to the Form Schedule.

Thank you for your attention to this matter, it is much appreciated. I am new to filing and we (SBLI Of MA) are new to both filing in Arkansas and to SERFF. It has been a very interesting experience.

Jim Coady

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 Product Name: Applications for Life Insurance
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Related Objection 1

Applies To:

- Life Insurance Application – Part 1 (Form)

Comment:

We did not find a Fraud Statement for Arkansas as referenced in Ark. Code Ann. 23-66-503(a).

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Life Insurance Application – Part 1	A-91AR		Application/Enrollment Form	Initial		50	A-91AR.pdf
Previous Version							
Life Insurance Application – Part 1	A-91		Application/Enrollment Form	Initial		50	A-91.pdf

No Rate/Rule Schedule items changed.

Sincerely,

Dwight Wilbur, James Coady, James MacDougall, Janice Albertazzi, Jason Brush

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 Product Name: Applications for Life Insurance
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Form Schedule

Lead Form Number: A-91

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	A-91AR	Application/ Life Insurance Enrollment	Application – Part 1 Form	Initial		50	A-91AR.pdf
	A-92	Application/ Life Insurance Enrollment	Application – Part 2 Form	Initial		50	A-92.pdf
	A-90	Other	Conditional Receipt Agreement	Initial		50	A-90.pdf
	A-91A	Other	Supplement to Life Insurance Application – Part 1	Initial		50	A-91A.pdf
	A-92A	Other	Supplement to Life Insurance Application – Part 2	Initial		50	A-92A.pdf
	A-93	Other	Supplement to Life Insurance Application	Initial		50	A-93.pdf
	AQ-8	Other	General Aviation Questionnaire	Initial		50	AQ-8.pdf
	AQ-9	Other	Commercial Aviation Questionnaire	Initial		50	AQ-9.pdf
	AQ-10	Other	Alcohol Questionnaire	Initial		50	AQ-10.pdf
	AQ-11	Other	Allergies Questionnaire	Initial		50	AQ-11.pdf
	AQ-12	Other	Asthma Questionnaire	Initial		50	AQ-12.pdf
	AQ-13	Other	Chest Pain Questionnaire	Initial		50	AQ-13.pdf
	AQ-14	Other	Diabetes Questionnaire	Initial		50	AQ-14.pdf
	AQ-15	Other	General Medical	Initial		50	AQ-15.pdf

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		Questionnaire				
AQ-16	Other	Kidney Stones Questionnaire	Initial	50		AQ-16.pdf
AQ-17	Other	Mental Health Questionnaire	Initial	50		AQ-17.pdf
AQ-18	Other	Seizures Questionnaire	Initial	50		AQ-18.pdf
AQ-19	Other	Colitis Questionnaire	Initial	50		AQ-19.pdf
AQ-20	Other	Drugs Questionnaire	Initial	50		AQ-20.pdf
AQ-21	Other	DUI Questionnaire	Initial	50		AQ-21.pdf
AQ-22	Other	Skin and SCUBA and Submersible Diving Questionnaire	Initial	50		AQ-22.pdf
AQ-23	Other	Substance Abuse Questionnaire	Initial	50		AQ-23.pdf
AQ-24	Other	Military Status Questionnaire	Initial	50		AQ-24.pdf
AQ-25	Other	Military Aviation Questionnaire	Initial	50		AQ-25.pdf
AQ-26	Other	Avocation and Professional Sports Questionnaire	Initial	50		AQ-26.pdf
AQ-27	Other	Hang Gliding Questionnaire	Initial	50		AQ-27.pdf
AQ-28	Other	Motor Sports Questionnaire	Initial	50		AQ-28.pdf
AQ-29	Other	Power and Motor Boat Questionnaire	Initial	50		AQ-29.pdf
AQ-30	Other	Unemployment Questionnaire	Initial	50		AQ-30.pdf
AQ-31	Other	Citizenship Questionnaire	Initial	50		AQ-31.pdf
AQ-32	Other	General Amendment	Initial	50		AQ-32.pdf
AM-5	Other	Updated Health Amendment	Initial	50		AM-5.pdf
AM-16A	Other	Agents Replacement	Initial	50		AM-16A.pdf

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Certification

AM-19M	Other	Children under UTMA as Beneficiary	Initial	50	AM-19M.pdf
AM-19MS	Other	Spouse, then Children under UTMA as Beneficiary	Initial	50	AM-19MS.pdf
AM-20	Other	Owner/Beneficiary	Initial	50	AM-20.pdf
AM-20B	Other	Trust, then Estate as Beneficiary	Initial	50	AM-20B.pdf
AM-20T	Other	Trust as Owner	Initial	50	AM-20T.pdf
AM-20BT	Other	Trust as Beneficiary and Owner	Initial	50	AM-20BT.pdf
AM-26	Other	Financial Disclosure Amendment	Initial	50	AQ-26.pdf
AM-28	Other	Nicotine Amendment	Initial	50	AM-28.pdf

The Savings Bank Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

In this application, "You" and "Your" refer to the Proposed Insured.

A. PRODUCT INFORMATION

<p>1. Product</p> <p><input type="checkbox"/> Level Term: <input type="checkbox"/> 10Yr <input type="checkbox"/> 15Yr <input type="checkbox"/> 20Yr <input type="checkbox"/> 25Yr <input type="checkbox"/> 30Yr</p> <p><input type="checkbox"/> Whole Life: <input type="checkbox"/> SL <input type="checkbox"/> L10 <input type="checkbox"/> L15 <input type="checkbox"/> L20 <input type="checkbox"/> L@65 <input type="checkbox"/> SPL</p> <p><input type="checkbox"/> YRT <input type="checkbox"/> Other: _____</p>	<p>2. Face Amount</p>	<p>3. Riders/Additional Benefits</p> <p><input type="checkbox"/> Term Insurance Rider Plan _____ \$ _____</p> <p><input type="checkbox"/> Child Insurance Rider \$ _____</p> <p><input type="checkbox"/> Waiver of Premium Rider</p> <p><input type="checkbox"/> Other: _____</p>	<p>4. Location of Sale (city, state)</p>
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B. PROPOSED INSURED INFORMATION

<p>1. Full Name (First, Middle, Last. Include maiden name)</p>	<p>2. Sex <input type="checkbox"/> M <input type="checkbox"/> F</p>	<p>3. Date of Birth (mm/dd/yyyy)</p>	<p>4. Birth State & Country</p>	<p>5. SSN</p>
<p>6. Home Address (Number, Street, City, State, Zip Code)</p>	<p>7. Phone and Email:</p> <p>Home #: _____ Cell#: _____ Work#: _____ Email: _____ Preferred method of contact: _____</p>			
<p>8. Driver's License Number State Issued: _____</p>	<p>9. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed # of dependents: _____ Ages: _____</p>	<p>10. U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", complete the Citizen Questionnaire and attach copy of green card or visa)</p>		
<p>11. Occupation (include duties)</p>	<p>12. Employer Name and Address</p>	<p>13. How long employed?</p>		
<p>14. Have you ever used tobacco or any other nicotine product or by-product of any type? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes"; Type: _____ How long used: _____ Last used: (mm/yyyy) _____ Amount & Frequency: _____</p>				
<p>15. How much life insurance does your spouse have in force with all insurers, including SBLI? \$ _____ Is your spouse also applying for insurance with SBLI? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", how much? \$ _____</p>				

C. OWNER/APPLICANT INFORMATION Complete only if Owner is to be other than the Proposed Insured. If Trust, give full name of Trust and date of Trust agreement.

<p>1. Type: <input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Other (Specify): _____</p>				
<p>2. Owner/Applicant/Trust Name</p>	<p>3. Date of Birth/Trust (mm/dd/yyyy)</p>	<p>4. Relationship to You</p>	<p>5. SSN/TIN</p>	
<p>6. Residence Address (Number, Street, City, State, Zip Code)</p>	<p>7. Email</p>	<p>8. Phone Numbers:</p>		
<p>9. Billing Address (Number, Street, City, State, Zip Code)</p>	<p>10. State Incorporated</p>	<p>11. Purpose of Trust</p>		
<p>12. Trust Contact Name</p>	<p>13. Type of Trust <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable</p>	<p>14. Name of Trustee(s)/Corporate Officer</p>		
<p>15. Does the above Trustee have sole authority to act on behalf of the Trust? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", list the names and addresses of all Trustees and obtain their signatures below. Attach a separate page, if necessary.)</p>				
<p>Trustee's Name</p>	<p>Address</p>	<p>Signature</p>		
<p> </p>	<p> </p>	<p> </p>		
<p> </p>	<p> </p>	<p> </p>		

Name of Proposed Insured

D. BENEFICIARY INFORMATION *If percentages are not given, shares will be distributed equally. Total percentage of primary beneficiaries' shares must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Attach separate sheet for additional beneficiaries.*

1. Primary Beneficiaries					
Full Name	Address	Date of Birth	SSN or TIN	Relationship to You	% Share

2. Contingent Beneficiaries					
Full Name	Address	Date of Birth	SSN or TIN	Relationship to You	% Share

3. If the beneficiary is a Trust or Corporation, provide name and date created:			
Name of Trust/Corporation	List Trustees if applicable	Date of Trust	State Incorporated

E. PROPOSED INSURED INSURANCE NEEDS *Complete either the Personal or Business Section. Explain "Yes" answers in the Remarks Section.*

Personal Section

1. Purpose of Insurance: <input type="checkbox"/> Income Replacement <input type="checkbox"/> Debt Repayment <input type="checkbox"/> Estate Conservation <input type="checkbox"/> Other (Specify):			
2. Gross Annual Income \$	3. Household Income \$	4. Net Worth \$	5. Within the last 5 years, have you filed for bankruptcy or had any judgments or liens filed against you? <input type="checkbox"/> Yes (Date of Discharge:) <input type="checkbox"/> No

Business Section

6. Purpose of Insurance: <input type="checkbox"/> Buy-Sell <input type="checkbox"/> Key Employee <input type="checkbox"/> Secure Credit <input type="checkbox"/> Other (Specify):		7. Is the business a: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other	
8. Type of Business		9. How long has the business been established?	
10. Total Liabilities \$	11. Net Worth \$	12. Within the last 5 years, has the business filed for bankruptcy or had any judgments or liens filed against it? <input type="checkbox"/> Yes (Date of Discharge) <input type="checkbox"/> No	
13. Net Profit after taxes for the past two years: Last Year: \$ Previous Year: \$	14. What % of the business is owned by you?	15. Your gross annual income with bonuses: \$	16. Amount of business insurance in force on your life: \$

17. In the Remarks section (J):
 a. If applicable, describe any insurance being applied for or in force on other key members of the business.
 b. If applicable, describe why there is no insurance being applied for or in force on other key members of the business.

F. PROPOSED INSURED PERSONAL HISTORY

1. Have you ever sold a policy or been involved in any discussions about the possible sale or assignment of this policy to a life settlement, viatical or other secondary market Provider/Producer? (If "Yes", provide details below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have any other applications or informal inquiries for life insurance pending with any other company, society or association in the last 12 months? (If "Yes", provide details below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited, withdrawn, or cancelled, or have you been asked to pay a higher premium? (If "Yes", provide details below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, in the last 3 years, resided or traveled, or do you intend to reside or travel, outside of the United States? (If "Yes", complete the Foreign Travel Questionnaire).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the last 3 years, has your driver's license been suspended or revoked, or have you received any moving violations? (If "Yes", provide details below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No

 Name of Proposed Insured

6. Have you ever been convicted of reckless driving, driving to endanger or driving under the influence of drugs or alcohol? (If "Yes", provide details below)..... Yes No
7. Except for traffic violations, have you been the subject of, or been convicted of, a misdemeanor or felony, or are you awaiting trial for a felony? (If "Yes", provide details below)..... Yes No
8. Have you in the last 3 years engaged in, or do you intend to engage in, flying a plane, racing motor boats or motor vehicles, or participate in sky-diving or parachuting, hang-gliding, hot air ballooning, mountain, rock or ice climbing, scuba diving or other hazardous activities? (If "Yes", complete the appropriate Hazardous Activities and/or Aviation Questionnaire) Yes No
9. Are you currently or intend to become a member of the Armed Forces, including the Reserves or National Guard? (If "Yes", complete the Military Questionnaire)..... Yes No

For any "Yes" answers, record details below: Use the overflow sheet if needed.

Question #	Explanation

G. PREMIUM PAYMENT INFORMATION (If "EFT" or "Credit Card", please fill in the EFT or Credit Card form. Credit Card available only for Initial Payment)

1. Initial Payment: <input type="checkbox"/> Check <input type="checkbox"/> COD <input type="checkbox"/> Credit Card <input type="checkbox"/> Electronic Fund Transfer (EFT) <input type="checkbox"/> Other (Specify):	2. Payment Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (EFT only)	3. Send Premium Notices to: <input type="checkbox"/> Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (Specify):
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4. Amount paid with Conditional Receipt Agreement (CRA): \$	5. Would you like to backdate your policy to save age? (If "Yes", see Backdating Disclosure section in the Notice to Proposed Insured and Owner)..... <input type="checkbox"/> Yes <input type="checkbox"/> No
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H. DIVIDEND OPTIONS (If this section is left blank or a selected option is not available, the default option will be Accumulate at Interest)

1. Pay in Cash (check) 2. Reduce amount due – any excess as: #4 #3 #1
 3. Purchase Paid Up Life Additions 4. Accumulate at interest

I. REPLACEMENT INFORMATION Applies to both Owner and Proposed Insured.

If you intend to replace existing coverage, please tell the Producer of your intention and answer "Yes" to replacement question #2 below. State law may require the Producer to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain, among other things, new suicide exclusions and contestability periods. Ask the Producer if you are unsure.

	Proposed Insured	Owner
1. Do you have an existing or pending life insurance policy or annuity contract? (If "Yes", provide details below. Complete state required replacement form for New NAIC Model Replacement Regulation States only)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you intend to replace any existing life insurance or annuity contract? (If "Yes", complete state required replacement form and provide details below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you considering using funds from an existing policy or contract to pay premiums on the policy you are applying for? (If "Yes", complete state required replacement form and provide details below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you stopped making premium payments, surrendered, forfeited, assigned to the Company, or otherwise terminated an existing policy or contract or are you considering doing so? (If "Yes", complete state required replacement form and provide details below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Insurance Companies (Do not include group policies)	Name of Insured	To be replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No	Contract / Policy #	Cash Value / Amount of Coverage	Date Issued
		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	

J. REMARKS (Use this section for explanations and special requests. Identify applicable Question and Section numbers.)

Name of Proposed Insured

K. AUTHORIZATION TO COLLECT AND DISCLOSE INFORMATION

This Authorization complies with the Health Insurance Portability and Accountability Act ("HIPAA")

I hereby authorize all the entities listed below that have provided payments, treatments or services to me, or on my behalf, to disclose to The Savings Bank Life Insurance Company of Massachusetts (the "Company") and its Producers, employees and representatives, including insurance support organizations, the following information: any and all information relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of alcohol, drugs, and tobacco; drug prescriptions and communicable diseases, including Human Immunodeficiency Virus (HIV) and AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner or health care professional;
- any hospital, laboratory, pharmacy, pharmacy benefit manager, clinic or other health care facility or provider;
- any insurance or reinsurance company;
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB)

This protected health information may be disclosed pursuant to this Authorization so that the Company can use it to:

- determine my eligibility for insurance;
 - underwrite my application and make risk rating, policy issuance and enrollment determinations;
 - determine my eligibility for benefits under the Conditional Receipt Agreement;
 - obtain reinsurance;
 - if a policy is issued, administer coverage, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and
 - conduct other legally permissible activities that relate to any insurance coverage I have or have applied for with the Company.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, medical practitioner, health care provider, hospital, clinic or any other health care provider to release and disclose my entire medical record without restriction. I understand that my health care providers can not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.
 - I further authorize the Company to release any information obtained by this Authorization to MIB, to other insurers in which I have policies or to which I may apply or to which a claim for benefits may be submitted, to reinsurers, and to other persons or organizations performing legal or business services in connection with my application or claim. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.
 - I authorize the Company to release to me, or to my physician, results that I may request of any medical or laboratory tests taken in connection with this application. In connection with a claim for benefits, this Authorization is valid no longer than the duration of the claim.
 - I also understand that failure to sign this Authorization statement, or subsequent revocation of this Authorization by me, may impair the ability of the Company to process my application or evaluate claims, and may be a basis for denying an application or claim for benefits.
 - By signing below I agree to the terms of this Authorization and acknowledge that I have read and understand it.

I may revoke this Authorization in writing at any time, except to the extent that action has been taken in reliance of this Authorization or to the extent the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself, by sending a written request to: The Savings Bank Life Insurance Company, P.O. Box 4048, Woburn, MA 01888. I understand that any information that is disclosed prior pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

This Authorization shall remain in force for 24 months following the date of my signature below or for the duration of any claim for benefits. A copy of this Authorization is as valid as the original. I understand that if I refuse to sign this Authorization to release my complete medical information, the Company may not be able to process my Application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

Date: _____ Signature of Proposed Insured (Parent, Guardian, Other*): _____

*If the insured is under the age of 18, signature of Parent Guardian Other: _____

Name of Proposed Insured

L. FRAUD WARNING

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and maybe subject to fines and confinement in prison.

M. REPRESENTATIONS

I, the Owner and the Proposed Insured signing below, agree that I have read the statements contained in the application or they have been read to me. I understand that the application includes the Application – Parts I and II and all supplemental forms or amendments the Company specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner.

I acknowledge that my answers to the above questions may result in higher premium rates or a denial in coverage.

I understand and agree that no Producer is authorized to (a) accept risks or pass upon insurability; (b) make or modify contracts; (c) waive the Company's rights or requirements; or (d) waive any information the Company requests.

I represent: (1) that the statements and answers I provided within the entire application are true, complete, and correct to the best of my knowledge and belief; (2) that the Company, believing the statements and answers to be true, complete, and correct, shall rely and act on them (3) the insurance being applied for is suitable for the Owner's insurance needs.

Under penalty of perjury, I certify that : a) the number shown is my correct taxpayer identification number and b) I am not subject to backup withholding because 1) I am exempt from backup withholding, or 2) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or 3) the IRS has notified me that I am no longer subject to backup withholding. The IRS does not require your consent to any provision of this document other than certification required to avoid backup withholding.

CROSS OUT ALL OF SUBPART "b)" IN THE PRECEDING PARAGRAPH IF YOU ARE SUBJECT TO BACKUP WITHHOLDING.

The Savings Bank Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

Professional health care provider ("care provider") means persons licensed as: medical physicians; chiropractors; physical therapists; psychologists; and drug, alcohol, or mental health counselors. **Professional health care treatment facility ("treatment facility")** includes: hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; and facilities or offices staffed or run by care providers.

A. PROPOSED INSURED INFORMATION

1. Full Name (First, Middle, Last) <i>John A. Doe</i>	2. Date of Birth (mm/dd/yyyy) <i>1/1/1970</i>	3. SSN <i>123 45 6789</i>
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B. MEDICAL HISTORY Please answer ALL medical history questions. Do not leave any questions blank. Explain "Yes" Answers in DETAILS

1. Primary Care Provider ("PCP")

Provide name, address and phone number of your PCP. For the past 5 years, describe dates, reasons consulted, and any treatments or medications prescribed in Section C, DETAILS, below. (If no PCP, provide names, addresses and phone numbers of care providers last seen, dates and the reasons for the visits. If none, state "NONE").

Name and address of PCP (or other care provider)	Phone Number	Dates Consulted	Reasons for Consultation	Treatments and Medications Prescribed
<i>Any Care Provider</i>	<i>123-4567</i>	<i>11/1/2007</i>	<i>ANY REASON</i>	<i>NONE</i>

2. Build

a. Height *Any* ft. *Any* in b. Weight *Any* lbs c. Have you had any weight change in excess of 10lbs. in the past year? Yes No

3. Personal Health History (For any "Yes" answers, provide details in Section C, DETAILS, below)

a. Have you ever had, been treated for, or been medically advised to be treated for any of the following?

	Yes	No		Yes	No		Yes	No
1. Anemia or other blood disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	16. Dizziness/Fainting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	31. Paralysis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Angina/Chest Pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	17. Emphysema	<input type="checkbox"/>	<input checked="" type="checkbox"/>	32. Pituitary Disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Anxiety/Depression/Mental Disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	18. Epilepsy/Seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	33. Prostate Disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Gastrointestinal/Esophageal Disorder/Ulcer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	34. Respiratory disorder, Chronic Cough, Spitting up blood	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Backache or Sciatica	<input type="checkbox"/>	<input checked="" type="checkbox"/>	20. Genito-urinary disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	35. Any sexually transmitted disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Bone, Joint or Arthritis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	21. Heart Attack or Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	36. Shortness of Breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Bronchitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	22. Heart Murmur/Rheumatic Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	37. Skin Disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	23. Hepatitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	38. Sleep Apnea	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Chronic Headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>	24. High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	39. Stroke	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Circulatory Disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	25. Kidney Disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	40. Sugar, Protein, or Blood in Urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Clotting Disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	26. Lupus(SLE)/Scleroderma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	41. Suicide Attempt	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Colitis/ileitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	27. Lymph Gland disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	42. Thyroid Disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13. Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	28. Multiple Sclerosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	43. Tuberculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14. Disease of the Brain or Nervous System	<input type="checkbox"/>	<input checked="" type="checkbox"/>	29. Palpitations/Arrhythmia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	44. Tumor, Mass or Lump	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15. Disease of the Liver or Gallbladder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	30. Pancreatitis or other disorder of the pancreas					

b. In the past 5 years, have you:

- consulted with or received treatment from a care provider or treatment facility?..... Yes No
- had an EKG, X-ray, or other diagnostic test, other than an AIDS-related test?..... Yes No
- been advised to have any diagnostic test, other than an AIDS-related test, hospitalization or surgery that was not completed?..... Yes No
- had medication prescribed for any other condition not listed in question 3(a), above?..... Yes No
- ever received or claimed disability or hospital indemnity benefits or pension for any injury, sickness, disability or impaired condition? Yes No

John A. Doe
Name of Proposed Insured

c. Have you ever:

1. sought or received advice, counseling or treatment by a care provider for the use of alcohol or drugs, including prescription drugs?.... Yes No
2. used cocaine, marijuana, heroin, narcotics, stimulants, sedatives, hallucinogens, controlled substance or any other drug, except as legally prescribed by a physician?..... Yes No
3. been diagnosed as having or been treated by a care provider for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
4. used alcoholic beverages? Yes No
If "Yes", type: _____ Frequency _____ Amount _____

d. Do you have any symptoms or knowledge of any other conditions that are NOT disclosed above? Yes No

4. Family History

a. Is there a history of diabetes, cancer, high blood pressure, heart or kidney disease, cardiovascular disease, alcoholism, mental illness, or suicide in your family?..... Yes No

b. Please complete the following:

	Age if Living	State of Health	Age of Death	Cause of Death	History of diabetes, cancer, heart disease or cardiovascular disease?
Father	62	Any			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No _____ Age of Onset _____ Type _____
Mother	62	Any			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No _____ Age of Onset _____ Type _____
<input type="checkbox"/> Brother <input checked="" type="checkbox"/> Sister	38	Any			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No _____ Age of Onset _____ Type _____
<input type="checkbox"/> Brother <input type="checkbox"/> Sister					<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Age of Onset _____ Type _____
<input type="checkbox"/> Brother <input type="checkbox"/> Sister					<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Age of Onset _____ Type _____
<input type="checkbox"/> Brother <input type="checkbox"/> Sister					<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Age of Onset _____ Type _____
<input type="checkbox"/> Brother <input type="checkbox"/> Sister					<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Age of Onset _____ Type _____
<input type="checkbox"/> Brother <input type="checkbox"/> Sister					<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Age of Onset _____ Type _____

C. DETAILS For any "Yes" answers. Identify applicable question. If additional space is needed, use overflow form.

State conditions, diagnoses, dates, durations, treatments, tests, medications prescribed and names, phone numbers and addresses of all care providers and treatment facilities.

John A. Doe
Name of Proposed Insured

D. AGREEMENT AND SIGNATURES

I, the Proposed Insured signing below, agree that I have read all of the statements contained in this entire application, or they have been read to me I understand and agree that no Producer is authorized to (a) accept risks or pass upon insurability; (b) make or modify contracts; (c) waive the Company's rights or requirements; or (d) waive any information the Company requests.

I represent: (1) the statements and answers given in the entire application are true, complete, and correct to the best of my knowledge and belief; (2) that The Savings Bank Life Insurance Company of Massachusetts, 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 acknowledge that I have received a copy or I have been read a copy of the Notice to Proposed Insured and Owner.

I agree that:

(a) I will notify the Company if any statement or answer given in the entire application changes prior to policy delivery; and
(b) except as provided in the Conditional Receipt Agreement (CRA), I understand and agree that even if I paid a premium, no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless the following three conditions are all met:

- (1) the policy has been delivered and accepted;
- (2) the full first modal premium for the delivered policy has been paid in full; and
- (3) there has been no change in the health of the Proposed Insured that would change the answers to any questions in the application, or any amendments thereto, before conditions (1) and (2) above have occurred.

I understand and agree that if all three conditions are not met:

- no insurance coverage will become effective; and
- the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded

Signature of Proposed Insured <i>John A. Doe</i>	Date <i>9/1/2008</i>	City, State <i>Any City, State</i>
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E. SIGNATURE(S) OF INTERVIEWER(S) - TO BE SIGNED BY ALL INTERVIEWERS, AS APPLICABLE

I certify that the information supplied by the Proposed Insured has been truthfully and accurately recorded on the Part II application.

If Producer recorded information:

Writing Producer Name <i>Any Producer</i>	Date <i>9/1/2008</i>	Writing Producer Number <i>12345</i>
Writing Producer Signature <i>Any Producer</i>	Countersigned (Licensed resident Producer if state required)	

If Tele-interviewer recorded information:

Name	Date
------	------

If Paramedical recorded information:

Examiner's Name	Date	Phone Number
Signature of Proposed Insured	Date	City, State

John A. Doe

Name of Proposed Insured

F. CUSTOMER IDENTITY INFORMATION :

To be completed by Producer or Paramed in physical proximity to the Proposed Insured (and Owner if different than Insured).

I have reviewed the Proposed Insured and Owner's (if applicable) identity document presented and recorded the following information:

Proposed Insured (and Owner if applicable) Name: <i>John A. Doe</i>		
Street Address <i>123 Any Street</i>	City and State <i>Any City, State</i>	Zip Code <i>98765</i>
Type of ID (Individual) (e.g. Drivers License) <i>DRIVERS LICENSE</i>		
Type of ID Document (Corporation/Trust) (e.g. Certificate of Good Standing or Trust)		
ID Number <i>12345</i>	Expiration Date: <i>Any Date</i>	
Signature of Producer or Paramed Authenticating Customer's Identity: <i>Any Producer</i>		
Producer/ Paramed Number <i>12345</i>	Date: <i>9/1/2008</i>	

The Savings Bank Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com
(Referred to herein as "The Company", "We", "Us", or "Our")

John A. Doc
Name of Proposed Insured

A. NOTICE TO PROPOSED INSURED AND OWNER

No insurance coverage will become effective before delivery of the policy applied for unless and until all of the conditions of this Agreement are met. If any conditions are not met, the Producer is not authorized to accept a premium and there will be NO COVERAGE. No Producer has the authority to alter or waive the terms or conditions of this Agreement. This Agreement shall be void if altered or modified.

B. PROPOSED INSURED'S REPRESENTATIONS

- | | |
|--|---|
| 1. Has the Proposed Insured: | |
| a. in the past 10 years had unintentional weight loss, or any symptoms of a disease or an impairment for which he/she has not consulted a physician or a member of the medical profession? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| b. in the past 5 years had, been treated for, been advised to be treated for, or now has, any type of heart disease or any other vascular disease, cancer, leukemia, malignant tumor, any disorder of the immune system, stroke, or alcohol or drug dependence or abuse? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| c. in the past 90 days, been admitted to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| d. been diagnosed as having Hepatitis C, Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 2. Is the Proposed Insured less than 15 days or more than 70 years old (age nearest birthday), on the date this Agreement is signed? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 3. Is the initial amount of life insurance coverage applied for on all applications pending with Us, including the current amount of all existing life insurance coverage with Us, greater than \$500,000? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

C. CONDITIONS WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY

1. All of the questions above are answered "NO"; and
2. An amount equal to the modal premium indicated on the application must be received by Us; the mode must be either annual, semi-annual, quarterly or monthly (two months' premium required); and
3. All medical examinations, tests, x-rays and electrocardiograms initially required by Our published rules with regard to age and amount requested for the risk class and plan applied for must be completed within ninety (90) days from the date this Agreement is signed; and
4. The Proposed Insured is, on the Effective Date, a risk acceptable for insurance exactly as applied for, or better, according to Our rules and practices, without modification of plan, premium rate or amount; and
5. On the Effective Date the state of health and all factors affecting the insurability of the Proposed Insured for coverage must be as stated in all application documents required by Us; and;
6. Any check, authorized withdrawal, credit card payment or any form of payment must be received and honored when first presented.

D. EFFECTIVE DATE

If all of the conditions above are met, then insurance coverage, subject to all the terms and conditions of the policy applied for and as if the policy applied for had already been issued and delivered, will become effective on the latest of: (a) the date of application; (b) the date of application - part II; (c) the date of completion of all underwriting requirements stated in Section (C)(3), above; or (d) the special policy date requested in the application, if any.

E. MAXIMUM AMOUNT

The maximum amount of life insurance coverage available under this Conditional Receipt Agreement shall be the lesser of: (1) the amount of insurance applied for in the application - part 1; or (2) \$500,000, minus the amount of insurance on the Proposed Insured's life in force with Us under any policies and Conditional Receipt Agreements, applied for or pending issue with Us, including Accidental Death Benefits; or (3) if death is due to suicide or intentional self-inflicted injury, the amount of premium paid will be refunded and no death benefit will be paid. There is no coverage beyond 70 years old (age nearest birthday) or below age 15 days.

F. REFUND OF MONEY

We will refund your money on the earliest of the following dates: (1) If any of the conditions above are not met; or (2) A policy resulting from the application is refunded; or (3) 90 days from the date this Agreement is signed. Our liability will be limited to the return of the amount paid with this Agreement. All returns will be made, without interest, to or for the benefit of the Owner. We may send a notice or return premium terminating this Agreement at any time before delivery of the policy.

John A. Doe

Name of Proposed Insured

G: AGREEMENT

I agree that: (1) the limited amount of insurance that may begin prior to policy delivery will not exceed the Maximum Amount as defined above; (2) this limited amount of insurance will not begin unless all of the CONDITIONS listed above are first met exactly; (3) this Agreement will be void if the Agreement or application contains any material misrepresentation, or if the Proposed Insured dies by suicide or intentional self-inflicted injury; and (4) this Agreement will automatically end on the earliest of the following dates: (a) the date the entire amount paid with this Agreement is returned, or (b) the date a policy is delivered to the Owner; or (c) 90 days from the date this Agreement is signed. I further agree to any remaining terms, limits, and conditions of this Agreement and the application. I understand that my payment herewith has not purchased immediate life insurance coverage.

Signature of Proposed Insured <i>John A. Doe</i>	Date <i>9/1/2008</i>	Signature of Owner/Applicant (if not Proposed Insured)	Date
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H: PRODUCER/BROKER STATEMENT

On the date below, I received the amount \$ 100.00 from John A. Doe in exchange for this Agreement. This Agreement bears the same date as the application – part I. I have accurately represented the terms and conditions of this Agreement to the Proposed Insured and Owner. I know of no reason why any person to be covered may not be eligible for insurance.

Signature of Producer <i>Any Producer</i>	Date <i>9/1/2008</i>
--	-------------------------

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER. DO NOT LEAVE THE PAYEE BLANK. CASH AND MONEY ORDERS WILL NOT BE ACCEPTED.

The Savings Bank Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

Name of Proposed Insured <i>John A. Doe</i>	Date of Birth <i>1/1/1970</i>	Social Security Number <i>123 45 6789</i>	Date of Application <i>9/1/2008</i>
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Additional Details (Use this space for explanations to any answers provided in application Part 1, or for any special requests. Identify applicable Question and Section numbers.)

Any additional Information

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Signature of Proposed Insured <i>John A. Doe</i>	Date <i>9/1/2008</i>	Signature of Owner/Applicant (if not Proposed Insured)	Date
Signature of Producer <i>Any Producer</i>	Date <i>9/1/2008</i>	Signature of Producer	Date
Producer Name Printed <i>Any Producer</i>	Producer Name Printed		

The Savings Bank Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

Name of Proposed Insured <i>John A. Doe</i>	Date of Birth <i>1/1/1970</i>	Social Security Number <i>123456789</i>	Date of Application <i>9/1/2008</i>
--	----------------------------------	--	--

I hereby request that the application on the life of the Proposed Insured be amended to include the following:

C. DETAILS For any "Yes" answers. Please identify applicable Question.

State conditions, diagnoses, dates, durations, treatments, tests, medications prescribed and names, phone numbers and addresses of all care providers and treatment facilities.

Any information

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Signature of Proposed Insured <i>John Doe</i>	Date <i>9/1/2008</i>	City, State <i>Any City, State</i>
If Producer recorded information:		
Signature of Writing Producer <i>Any Producer</i>	Date <i>9/1/2008</i>	City, State <i>Any City, State</i>
If Tele-interviewer recorded information:		
Name	Date	
If Paramedical recorded information:		
Examiner's Name	Date	Phone Number

The Savings Bank Life Insurance Company of Massachusetts
One Linscott Road, Woburn MA 01801
Telephone (800) 694-7254 www.sbli.com

A. PROPOSED INSURED

1. Full Name (First, Middle, Last) <i>John A. Doe</i>	2. Date of Birth (mm/dd/yyyy) <i>1/1/1970</i>	3. SBLI Reference # <i>12345</i>
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B. APPLICATION UPDATE

Since the later of the date of the application for life insurance or the insurance exam:

1. Has the Proposed Insured's health, either mental and/or physical, changed? Yes No

2. Has the Proposed Insured:

Had any illness, surgical operation or injury? Yes No

Consulted or been advised to see a doctor for any reason? Yes No

Been advised to have an operation or diagnostic test that has not been completed? Yes No

Had life, accident or health insurance:

Postponed or declined? Yes No

Cancelled? Yes No

Renewal of reinstatement refused? Yes No

Rated with an extra premium? Yes No

Details of any "Yes" answers:

C. REPRESENTATION AND SIGNATURE(S)

REPRESENTATION:
To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that The Savings Bank Life Insurance Company of Massachusetts ("SBLI"), believing them to be complete, correct, and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

SIGNATURE(S)

Proposed Insured <i>John A. Doe</i>	Date <i>9/1/2008</i>	Owner/Applicant (if not Proposed Insured)	Date
Producer <i>Amy Producer</i>	Date <i>9/1/2008</i>	Producer	Date

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
Please Read Carefully and Sign Below

General Aviation Questionnaire

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Please provide details in #7 below of any items you are asked to "Describe".

1. (A) Total of all hours flown as a pilot, crew member, or passenger. Hours: *Any*
 (B) Total hours flown in the past 12 months. Hours: *Any*
 (C) Estimated hours flying in the next 12 months. Hours: *Any*
2. (A) Pilot certificate currently held: Student Private Commercial
 (B) Date of issue: *Any date*
 (C) Have you ever been grounded or had your license revoked? No Yes (Describe)
3. (A) Medical Certificate now held: III II I
 (B) Date last renewed: *Any date*
 (C) Was a Medical Certificate ever denied, issued only after an appeal, and/or ever issued subject to any limitations or medical waiver(s)? No Yes (Describe)
4. Are you now, have you within the past 12 months, or do you contemplate future flying in the Civil Air Patrol?
 No Yes (Describe)
5. Do you contemplate a change from your present flying to commercial or military flying? No Yes (Describe)
6. Date of last flight as: Passenger: *1/1/2008* Pilot: *2/1/2008*
 Crew member: *3/1/2008* Other: *4/1/2008*

7. Details: Specify question number(s) for which you are providing details. Include all pertinent information:

8. If not qualified for full coverage at standard rates, I request the following (if applicable):
 Full coverage with an extra premium. Restricted coverage with no extra premium.

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the Proposed Insured

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Please provide details in #4 below of any items you are asked to "Describe".

- (A) Pilot Certificate currently held: Commercial Airline Transport
 Special (Describe) Other (Describe)
 (B) Date of last renewal: *Any Date*
 (C) Have you ever been grounded or had your license revoked? No Yes (Describe)
- (A) Medical Certificate currently held: II I
 (B) Date last renewed: *Any Date*
 (C) Was Medical Certificate ever denied, issued only after an appeal and/or ever issued subject to any limitations or medical waiver(s)? No Yes (Describe)
- Flying Activities: Check every major category and underscore each following descriptive word or phrase applicable to your flying (past 12 months, current or contemplated):

- | | |
|--|---|
| <input type="checkbox"/> AGRICULTURE, CROP, INSECT CONTROL
(dusting, spraying) conventional or rotorcraft | <input type="checkbox"/> MEDICOPTER |
| <input checked="" type="checkbox"/> AIRLINE passenger, cargo, regional, national, international, with 1 U.S. or Canadian terminal scheduled, non-scheduled, other (Describe) | <input type="checkbox"/> MINING, QUARRYING, OIL, NATURAL GAS exploration, prospecting, supply (cargo), transportation |
| <input type="checkbox"/> AIRTAXI (3rd level airline) passenger, cargo, mail | <input type="checkbox"/> PHOTOGRAPHING |
| <input type="checkbox"/> BUSH (Arctic Region) | <input type="checkbox"/> POLICE, LAW ENFORCEMENT SEARCH, RESCUE, RECOVERY |
| <input type="checkbox"/> BUSINESS (company owned plane) equipment and maintenance comparable to scheduled airline, other (Describe) | <input type="checkbox"/> RACING cross-country, pylon, stock, formula 1 |
| <input type="checkbox"/> CHARTER passenger, cargo | <input type="checkbox"/> REPORTING |
| <input type="checkbox"/> CONSTRUCTION sling loads, other (Describe) | <input type="checkbox"/> STUDENT INSTRUCTION |
| <input type="checkbox"/> EXPLOSIVES TRANSPORTATION | <input type="checkbox"/> STUNTING |
| <input type="checkbox"/> FERRY SERVICE | <input type="checkbox"/> SURVEYING |
| <input type="checkbox"/> FIRE FIGHTING, control cargo, detection, transportation, conventional plane, rotorcraft, forest fire bomber, forest ranger, fire warden | <input type="checkbox"/> TESTING approved planes, approved rotorcraft, experimental planes, experimental rotorcraft, hypersonic aircraft, rocket flying belt, flying platform, other (Describe) |
| <input type="checkbox"/> FISH, GAME WARDEN | <input type="checkbox"/> TRAFFIC SPOTTING, CONTROL, PATROL |
| <input type="checkbox"/> INSPECTION pipe, power line, telephone line, other (Describe) | <input type="checkbox"/> WEATHER CONTROL, cloud seeding, fog seeding, reconnaissance, hurricane watch, other (Describe) |
| <input type="checkbox"/> MAPPING | <input type="checkbox"/> ANY OTHERS NOT LISTED ABOVE |

4. Details: Specify question number(s) for which you are providing details. Include all pertinent information:

5. If not qualified for full coverage at standard rates, I request the following (if applicable):
 Full coverage with an extra premium Restricted coverage with no extra premium.

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008 _____ Date
John Doe _____ Signature of Proposed Insured (if age 15 or over)
 _____ Signature of Applicant, if other than the Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
John A. Doe	9/1/2008	12345

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The following questions regarding alcohol consumption are fairly common throughout the insurance industry. They are in no way intended to imply that you have or had a problem with alcohol.

1. How much and how often do you consume alcohol? *Any Amount*
2. What was the date of your last drink? *Any Date*
3. Have you ever been told you have or had a known problem with alcohol? *NO*
4. Are you now or have you ever been a member of Alcoholics Anonymous?
(Not applicable for policies to be issued in Connecticut.) *NO*
5. How much and how often did you formerly drink? *Any Amount*
6. Have you ever stopped drinking and restarted? *NO*
7. Have you ever received treatment for alcohol or other drug abuse? If so, please provide the date(s) of all treatment plans/admissions and the name of the doctor / facilities. *NO*
8. Have you ever been convicted of driving under the influence of alcohol? *NO*

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008

Date

John A. Doe

Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The following questions relate to the person proposed for insurance and his/her history of allergies.

1. What substance(s) are you allergic to and what types of allergic reaction do you have?

Any Substance
Any Reaction

2. Have you ever, or are you currently taking any medication for allergies? Please list dates and types.

No

3. Please provide the complete names and addresses of the doctor and/or hospitals that have treated you for allergies.

None

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The following questions relate to the person proposed for insurance and his/her history of asthma.

1. List the number of episodes of this condition you have had and the dates. List the date of most recent attack.

Any number, Any dates

2. Please provide the complete names and addresses of the doctor and/or hospitals that have treated you for asthma.

Any Provider or facility

3. Has Prednisone ever been prescribed? No Yes

If "Yes": When?

How often is it prescribed?

How much do you take and for how long?

4. Where and when was your last Chest X-Ray or Pulmonary Function Test performed?

Any Date, Any location

5. Have you ever been hospitalized for asthma? If yes, give dates and duration of admission.

No

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008

Date

John A. Doe

Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:
 The following questions relate to the person proposed for insurance and his/her history of chest pain.

1. Please describe the proposed insured's chest pain as to:

A. Characteristics:

Any Characteristics

B. Duration:

Any Duration

C. Frequency:

Any Frequency

D. Severity:

Any Severity

2. What was the diagnosis?

Any diagnosis

3A. Approximate date of first episode?

Date

3B. Date of most recent episode?

Date

4. What treatment has been prescribed?

Any treatment

5. Where any of the following performed:

A. Electrocardiogram:

No

Yes - Date? _____

B. Exercise Test:

No

Yes - Date? _____

C. Coronary Arteriography:

No

Yes - Date? _____

D. Holter Monitor

No

Yes - Date? _____

E. Chest X-Ray

No

Yes - Date? _____

F. Cardiac Echocardiogram:

No

Yes - Date? _____

6. Please provide the complete names and addresses of the doctor and/or hospitals that have treated you for chest pain.

Any Names
Any addresses

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008

Date

John A. Doe
 Signature of Proposed Insured
 (if age 15 or over)

 Signature of Applicant, if other than the
 Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The following questions relate to the person proposed for insurance and his/her history of diabetes.

1. When was your diabetes first diagnosed?

Any Date

2. What type of treatment do you use? (diet, oral medication, or Insulin) and how much per day?

Any Treatment

3. If you use insulin, how many times a day do you administer it?

One or two times a day

Three or more times a day

Insulin Pump

Any Number

4. Please provide the complete names and addresses of the doctor and/or hospitals that have treated you for diabetes.

Any Names
Any Addresses

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The following questions relate to the person proposed for insurance and his/her history of *Any condition*

1. Please advise the number of occurrences of this condition you have had, and the dates.

Any number, Any dates

2. Have you ever been hospitalized for this condition? If "yes", when and where?

No

3. What medications, if any, have been prescribed? Are you on medication at present?

NONE NO

4. Have you ever had treatment other than medication? If "yes", please explain.

No

5. Please provide the complete names and addresses of the doctor and/or hospitals that have treated you for *Any condition*

*Any Names
Any Addresses*

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The following questions relate to the person proposed for insurance and his/her history of kidney stones.

1. What is the number of occurrences that you have had and the dates?

*Any number
Any Dates*

2. Did the stones pass spontaneously? If not, what procedure, if any, was performed?

yes

3. Please provide the complete names and addresses of the doctor and/or hospitals that have treated you for kidney stones.

*Any Names
Any Addresses*

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The following questions relate to the person proposed for insurance and his/her mental health history.

1. What were you, or are you, being treated for? (Anxiety, depression, obsessive compulsive disorder, panic attacks, other.) *Any Condition*

Please provide the "from – to" dates of treatment and indicate if still ongoing.

Any Dates

2. What medication, if any, is/was prescribed and by whom? Are you still taking the medication?

Any medications
Any Name

3. Are you, or have you, been seen in counseling/psychotherapy? If yes, when and by whom were/are you seen?

No

4. Please provide the complete names and addresses of the doctor and/or hospitals that have treated you for the condition.

Any Names
Any Addresses

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The following questions relate to the person proposed for insurance and his/her history of seizures.

1. What type of seizures do you have?

Any type

2. What was the date of your first seizure?

Any date

3. What was the date of your last seizure?

Any date

4. Please provide the complete names and addresses of the doctor and/or hospitals that have treated you for seizures.

Any names
Any addresses

5. What type of medication, if any, have/are you been prescribed in an effort to control your seizures.

Any medications

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008

Date

John A. Doe

Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The following questions relate to the person proposed for insurance and his/her history of Colitis.

1. Please advise the number of occurrences of this condition you have had, and the dates.

Any Number, Any dates

2. Have you ever been hospitalized for this condition? If "yes", when and where?

No

3. What medications, if any, have been prescribed? Are you on medication at present?

NONE

4. Have you ever had treatment other than medication? If "yes", please explain.

No

5. Please provide the complete names and addresses of the doctor and/or hospitals that have treated you for Colitis.

Any names
Any addresses

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008

Date

John A. Doe

Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The following questions relate to the person proposed for insurance and his/her history of drug use.

1. What kind of drugs have you used?

Any Drugs

2. What was the date you last used drugs?

Any Date

3. Please provide the full names and addresses or any doctor or facility that may have treated you for this condition.

Any Names
Any Addresses

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

1. How many times have you been charged with driving under the influence? Please provide the dates.

Any Number, Any Dates

1. Have you had a problem with alcohol or other drugs?

No

1. Was a period of treatment required? If so, what type?

No

1. Please provide the full names and addresses or any doctor or facility that may have treated you and the dates of the treatment.

*Any Names
Any Addresses*

1. Are you now or have you ever been a member of Alcoholics Anonymous?
(Not applicable for policies to be issued in Connecticut.)

No

1. What was the date of your last drink?

Any Date

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)
 One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
 Please Read Carefully and Sign Below

Skin and SCUBA and Submersible Diving Questionnaire

Proposed Insured	Application Dated	Policy Number
John A. Doe	9/1/2008	12345

I hereby request that the application on the life of the proposed insured be amended to read as follows:

What type of equipment do you use? (Skin, SCUBA, Submersible) Any equipment

What are the locations of your diving activities? (Cave, under ice, ocean, inland waters, etc.) Any location

Please provide details of any "Yes" answers in the "Remarks" section below

Are you currently certified by one of the national training and certification organizations? If "Yes", Name of Organization _____ No X Yes _____

Are you a member of an organized club? _____ No X Yes _____

Do you ever dive alone? _____ No X Yes _____

Do you now dive or contemplate diving for compensation? _____ No X Yes _____

Particulars of Diving

Depth of Dives Diving or Submerging:	Number of Dives	Average Time Underwater per Dive	Expected Next 36 Months
			Number of Dives
30 feet or less	#	time	#
To 50 feet	#	time	#
To 75 feet	#	time	#
To 100 feet	#	time	#
To 150 feet	#	time	#
To 200 feet	#	time	#
Over 200 feet	#	time	#

Remarks: Any Remarks

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008 _____
 Date Signature of Proposed Insured - John A. Doe

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
John A. Doe	9/1/2008	12345

I hereby request that the application on the life of the proposed insured be amended to read as follows:

The date of your last drink? Any Date

1. Are you now or have you ever been a member of Alcoholics Anonymous? (Not applicable for policies to be issued in Connecticut.) No

2. Please provide the full names and addresses or any doctor or facility that may have treated you for this condition.

Any Names
Any Addresses

3. The kinds of drugs you may have used.

Any Drugs

4. The date you last used drugs.

Any Date

5. Please provide the full names and addresses or any doctor or facility that may have treated you for this condition.

Any Names
Any Addresses

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
Please Read Carefully and Sign Below

Military Status Questionnaire

Table with 3 columns: Proposed Insured, Application Dated, Policy Number. Handwritten entries: JOHN A. DOE, 9/1/2008, 12345

I hereby request that the application on the life of the proposed insured be amended to read as follows:

A. TO BE COMPLETED BY APPLICANTS CONTEMPLATING MILITARY SERVICE

- 1. Do you contemplate enlisting or making application for military service? No [X] Yes ___
2. Are you in any ROTC unit? No [X] Yes ___
3. Are you now or do you intend to become a cadet at any service academy? No [X] Yes ___
4. Are you now, have you ever been, or do you intend to become a pilot or crew member of an aircraft? No [X] Yes ___

B. TO BE COMPLETED BY MILITARY PERSONNEL ON ACTIVE DUTY OR IN THE RESERVE OR NATIONAL GUARD

- 1. Are you now on active duty? No ___ Yes ___
2. If not on active duty, are you a member of the Active Reserve, Inactive Reserve or National Guard? No ___ Yes ___
3. Have you been alerted for or requested active duty? No ___ Yes ___
4. Are you now, have you ever been, or do you intend to become a pilot or crew member or an aircraft? No ___ Yes ___
5. Have you received or requested any special training or schooling? No ___ Yes ___
6. Have you been alerted or volunteered for, expect, or have any foreknowledge of, duty outside the Continental United States? No ___ Yes ___

Remarks: _____

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

Signature of Proposed Insured

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
Please Read Carefully and Sign Below

Military Aviation Questionnaire

TO BE COMPLETED BY APPLICANTS WHO HAVE ANSWERED "YES" TO A-4 AND/OR B-4 OF MILITARY STATUS QUESTIONNAIRE

Proposed Insured	Application Date	Policy Number
John A. Doe	9/1/2008	12345

I hereby request that the application on the life of the proposed insured be amended to read as follows:

1. Please check the appropriate line designating your service.

- Any*
- | | |
|--|---|
| <input type="checkbox"/> A. United States Air Force | <input type="checkbox"/> F. National Guard |
| <input type="checkbox"/> B. United States Army | <input type="checkbox"/> G. Reserves |
| <input type="checkbox"/> C. United States Navy | <input type="checkbox"/> H. ROTC or Service Academy |
| <input type="checkbox"/> D. United States Coast Guard | <input type="checkbox"/> I. Civil Air Patrol |
| <input type="checkbox"/> E. United States Marine Corps | <input type="checkbox"/> J. Other (Specify) |

2. Specify aviation activity and duties. If crew member, give job title.

Any Activity
Any Job Title

3. Specify duty assignment (MAC, SAC, TAC, etc.)

Any Assignment

4. Specify aircraft in which duties performed (A6, B52, T46, UH60, etc.)

Any aircraft

5. Do you contemplate or have any knowledge of any change in activities?
(If "Yes", give full details under "Remarks") No Yes
6. Are you a member of an aerobatic or precision flying team?
(If "Yes", give full details under "Remarks") No Yes
7. Do you fly for proficiency only?
(If "Yes", specify hours flown and full details under "Remarks") No Yes

Remarks:

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured -

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
 Please Read Carefully and Sign Below
Avocation and Professional Sports Questionnaire

Proposed Insured	Application Dated	Policy Number
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Check "Yes" for all appropriate Avocations and Professional Sports Activities in which you participate and corresponding time frames.

Yes	Activity	Past 12 months and/or currently	Next 12 months and/or currently
	Aquascooters		
	Balloonists		
	Bicycle Riders (indicate in "Remarks" whether Sprint, Pursuit, or Motor Pace)		
	Boatload		
	Bobsled Racers (2 and 4 Man)		
	Boxers and Prizefighters (Professional)		
	Canoe and Kayak Competitors - Tobogganers, Sledders		
	Canoe and Kayak Competitors - White Water Slalom, Downriver		
	Cliff Divers - International Competitors and Professionals		
	Cliff Divers - Others (give details in "Remarks")		
	Dune Scooters		
	Hang Balloonists		
	Horse Racers & Competitors - Harness Racing Drivers (Pacing and Trotting)		
	Horse Racers & Competitors - Jockeys		
	Horse Racers & Competitors - Steeplechase Riders		
	Hunters - Big Game (give details in "Remarks")		
	Kiters		
	Laserteers		
	Luge Racers (1 and 2 Man)		
	Motorboard Surfers		
	Mountain Climbers		
	North American Continent - Rock Climbers		
	North American Continent - Trail Climbers		
	Elsewhere - Rock Climbers		
	Elsewhere - Trail Climbers		
	Para-Gliders		
	Para-Kiters		

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

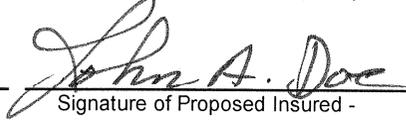
One Linscott Road, Woburn, MA 01801 800-694-7254

Avocation and Professional Sports Questionnaire - continued

Yes	Activity	Past 12 months and/or currently	Next 12 months and/or currently
	Para-Sailors		
	Para-SCUBA		
	Power Skiers		
	Rocketeers		
	Experimental metal rockets using home-mixed propellents		
	Rodeo - Clowns (Professional)		
	Rodeo - Performers - Amateur		
	Rodeo - Performers - Professional		
	Sand Surfers		
	Sand yacht Racers		
	Skiers - Acrobats		
	Skiers - Ski Jumpers, Downhill racers		
	Skydivers and Sport Parachutists - Amateur		
	Skydivers and Sport Parachutists - Professional		
	Affiliated with Parachute Club		
	Not Affiliated with Parachute Club		
	Spelunkers (Members of Search and Rescue Units)		
	Surfers - International Competitors and Professionals		
	Surfers - Others		
	Target Divers - International Competitors and Professionals		
	Target Divers - Others		
	Water Kites		
	Water Skiers - International Competitors and Professionals		
	Water Skiers - Water Ski Racing		
	Water Skiers - Water Speed Records		
	Wrestlers		

Remarks: _____

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:
 9/1/2008 
 Date Signature of Proposed Insured -

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
Please Read Carefully and Sign Below

Hang Gliding Questionnaire

Proposed Insured	Application Dated	Policy Number
John A. Doe	9/1/2008	12345

I hereby request that the application on the life of the proposed insured be amended to read as follows:

How frequently do you hang glide? ANY FREQUENCY

Are you a member of an organized club? No X Yes _____

Do you fly professionally? No X Yes _____

How high do you usually fly? Any Altitude

What is the greatest height Any height, distance Any, duration Any flown?

Have you or do you intend to attempt any height, distance, or duration records? No X Yes _____
If "Yes", give details. _____

Have you ever flown or do you intend to fly experimental equipment of either manufacturer's or your own design? No X Yes _____
If "Yes", give details. _____

Remarks: _____

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured -

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
 Please Read Carefully and Sign Below
Motor Sports Questionnaire

Proposed Insured	Application Dated	Policy Number
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:
 Do you engage in exhibition or organized competitive motor sports? No Yes

Check below the type(s) of events you pursue:

- | | | |
|--|--|--|
| <input type="checkbox"/> All Terrain (ATV) | <input type="checkbox"/> Auto-Crash | <input type="checkbox"/> Auto-Ice |
| <input type="checkbox"/> Championship Cars | <input type="checkbox"/> Demolition or Destruction Derby | <input type="checkbox"/> Drag Racing |
| <input type="checkbox"/> Dune or Sand Buggy or Cycle | <input type="checkbox"/> Economy Runs | <input type="checkbox"/> Figure 8 Demolition Derby |
| <input type="checkbox"/> Football Demolition Derby, | <input type="checkbox"/> Formula Racing | <input type="checkbox"/> Gyro-Stabilized Land or |
| Auto Football or Soccer | <input type="checkbox"/> Hovercraft and Hydrofoils, | Water Vehicles |
| <input type="checkbox"/> Jet Car Exhibitions | <input type="checkbox"/> Amphibians | <input type="checkbox"/> Kart Racers |
| <input type="checkbox"/> Midget Cars | <input type="checkbox"/> Mini Cars | <input type="checkbox"/> Motorcycles |
| <input type="checkbox"/> Off Road, Desert, Trail Competition | <input type="checkbox"/> Pikes Peak Hillclimb | <input type="checkbox"/> Rally |
| <input type="checkbox"/> Scooters | <input type="checkbox"/> Snow Beetles | <input type="checkbox"/> Snowmobiles |
| <input type="checkbox"/> Sports Cars | <input type="checkbox"/> Sprint Cars | <input type="checkbox"/> Stock Cars |
| <input type="checkbox"/> Swampbuggies | <input type="checkbox"/> Time Speed Trials | <input type="checkbox"/> Wheelie Competitions |
| <input type="checkbox"/> Others (explain in "Remarks" below) | | |

What specific type of event do you compete in with the above vehicle(s)? (road race, endurance, sprint, etc.)

What class do you compete in? (Be specific; include make model, engine size, class designation of your vehicle)

Under what sanctioning body do you normally compete? (AMA, NHRA, USAC, etc.) _____

Do you compete professionally? No Yes

How many races or events did you participate in, last twelve months? _____

How many do you anticipate you will participate in, next twelve months? _____

What is the average length of these events? (In miles, laps, or time, as appropriate). _____

What is the average speed? _____ What is the top speed? _____

Do you anticipate any changes in your participation in the coming twelve months? No Yes

If "Yes", give details. (Different events, new class, etc.) _____

Remarks: _____

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008 *John A. Doe*

 Date Signature of Proposed Insured -

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)
 One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
Please Read Carefully and Sign Below
Powerboat or Motorboat Questionnaire

Proposed Insured	Application Dated	Policy Number
John A. Doe	9/1/2008	12345

I hereby request that the application on the life of the proposed insured be amended to read as follows:
 Do you engage in any power or motor boating events, exhibitions or competitions? No Yes

Check below the type(s) of events you pursue:

- | | |
|--|---|
| <input type="checkbox"/> Closed Course | <input type="checkbox"/> Straight Away |
| <input type="checkbox"/> Drag Racing | <input type="checkbox"/> Time Speed Trials |
| <input type="checkbox"/> Marathon | <input type="checkbox"/> Other (explain in "Remarks") |
| <input type="checkbox"/> Offshore | |

What type of craft do you use? (Hydro, Runabout, etc.) _____

What specific class do you compete in? _____

How many races or events did you participate in, last twelve months? _____

How many do you anticipate you will participate in, next twelve months? _____

What is the average length of these events? (In miles, laps, or time, as appropriate). _____

What is the average speed? _____ What is the top speed? _____

Do you anticipate any changes in your participation in the coming twelve months? No Yes

If so, give details. (Different events, new class, etc.) _____

Remarks: _____

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008 John A. Doe
 Date Signature of Proposed Insured -

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

1. What is the reason you are unemployed?

Any Reason

If unemployed for medical reasons, please indicate the medical condition and the name and address of the doctor or hospital treating you.

2. What is your usual occupation?

Any occupation

3. Please provide your work history for the past 5 years, specifically including the date you last worked.

Any history

4. What are your future occupation plans?

Any plans

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

1. How long have you been living in the United States?

Any Duration

2. Are you a citizen of the United States or working to become a citizen?

Yes

3. Are you planning on returning to your previous country of residence on a permanent or temporary basis (other than vacation)?

No

4. Please list all occupations, and dates of employment, you have had for the past 5 years.

Any occupations, Dates

5. Please provide **front and back copies** of your Social Security card, your Green Card or any other papers that certify to your being a permanent resident of the United States.

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request. I further acknowledge that my answers to the above questions may result in higher premium rates or a denial of coverage.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured,

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)
One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9-1-2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Any application related information

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Please be sure to complete all questions and sign and date this form.

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Have you changed your employment status within the past year? O Yes No
If "Yes", please provide details below.

Who is your personal physician? (If you do not have one, so state.)
 Name: *ANY NAME* Telephone number: *ANY #*
 Address: *ANY ADDRESS* Date last seen: *ANY DATE*
 City, State, Zip: Reason and results of visit: *ANY REASON*

Are you now taking, or have you been advised to take, any medications? O Yes No
If "Yes", please explain:

Do you have any medical consultations scheduled? O Yes No
If "Yes", please explain:

If you lost weight in the past year, please state how much: _____ lbs. and the reason for the loss:

What is your height? _____ Feet _____ Inches What is your weight? _____ lbs.

Are you a U.S. Citizen? If "No", Country of citizenship _____ Yes O No
 Visa Type: _____ Expiration date: _____, and attach a copy of your documentation.

Have you, in the last 3 years, resided or travelled, or do you intend to reside or travel outside of the United States? O Yes No

In the last 3 years, have you had your driver's license suspended or revoked, or received any moving violations? O Yes No

Have you ever been convicted of reckless driving, driving to endanger or driving under the influence of drugs or alcohol? O Yes No

Have you ever been convicted of a misdemeanor (other than a traffic violation) or felony or are you awaiting trial for a felony? If "Yes", give details, dates, and circumstances.) O Yes No

Have you in the last 2 years engaged in, or do you intend to engage in, any hazardous activities or sports such as hang gliding, hot air ballooning, ultra light flying, mountain or rock climbing, motor vehicle or boat racing, scuba diving, sky diving or parachuting? O Yes No

Are you, or do you intend to become, a member of the Armed Forces, including Reserves? O Yes No

Have you ever owned, operated, been, or intended to be, licensed to operate an airplane? O Yes No

How many flights have you made in the last 12 months in other than a Commercial airline/airplane? *0*

How many flights do you plan to make in the next 12 months in other than a Commercial airline/airplane? *0*

This is a 2 sided form. Please complete and sign the reverse side.

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment -- *continued*

Proposed Insured: *John A. Doe*

Policy Number: *12345*

Have you ever: (Please explain "Yes" answers in "Details" area.)

- a. Used narcotics, hallucinogens, barbiturates, heroin, cocaine, amphetamines, sedatives or any other habit-forming drugs except as prescribed by a physician? Yes No
- b. Been advised by a physician, psychiatrist or psychologist to quit or reduce alcohol use? Yes No
- c. Been advised to seek, or received treatment or counseling for alcohol or other drug use? Yes No
- d. (Not applicable in Connecticut) Been advised to attend or been a member of any self-help group? Yes No
- e. Been convicted of drug possession or distribution? Yes No
- f. Had, or been advised to have, any surgery? Yes No
- g. Been treated or been advised to have treatment in any hospital or clinic or similar institution? Yes No
- h. Had any X-Rays, electrocardiograms, blood tests or any other medical tests? Yes No
- i. Been disabled? Yes No
- j. Attempted suicide? Yes No

DETAILS: Please provide details of all "Yes" answers. List the question number. Include diagnosis, dates, duration, full names and address of all attending physicians and medical facilities. Give reasons for checkup, treatment and medication.

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS
APPLICATION AMENDMENT
- AGENT CERTIFICATION -

Proposed Insured <i>John A. Doe</i>		Application Dated <i>9/1/2008</i>	Reference Number <i>12345</i>
Amount Applied for <i>\$100,000</i>	Kind applied for <i>Any Kind</i>	Agency Name <i>Any Agency</i>	Agency Number <i>Any #</i>

Does the sale of this insurance involve a replacement of an existing life insurance policy or annuity (other than SBLI)?

Yes (submit form A-52)

No

I hereby certify that I have completed the application on the proposed insured named above.

PLEASE SIGN HERE:

9/1/2008 *Any Agent, Ind. #* *X Any Agent*
Date Agent's Name & Number (please print) Signature of Agent

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Question #20: Beneficiary

The net proceeds under each of the policies herein applied for shall be paid as follows:

To the Insured's surviving children in equal shares. Except that if any child of the Insured has not attained the age of eighteen (18) years on the date of payment, then payment should be made to, as Custodian for each minor child under the Massachusetts Uniform Transfers to Minors Act, without any responsibility on the part of The Savings Bank Life Insurance Company of Massachusetts as to the application of such payment by the Custodian. A separate custodianship will be created for each minor child of the Insured then living. I hereby nominate as the Successor Custodian if the original Custodian is no longer living or is unable to serve as Custodian at the time payment(s) are made.

The Insured's current children are listed below. All subsequent children are to be included in equal shares. All proceeds will be paid equally or the whole to the survivor.

Child's Name and Sex:	Birth Date:
<i>Any Name + Sex</i>	<i>Any Date</i>

All decisions made by SBLI in good faith as to the identity of the beneficiaries not designated by name shall be conclusive as to SBLI's liability and any payment made in accordance therewith shall, to the extent thereof, discharge SBLI of its obligation for such payment.

Please Sign Here:

9/1/2008
 Date

John A. Doe
 Signature of Proposed Insured
 (if age 15 or over)

 Signature of Applicant, if other than the
 Proposed Insured

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Question #20: Beneficiary

The net proceeds under each of the policies herein applied for shall be paid as follows:

To the Insured's spouse, if living, otherwise to the Insured's surviving children in equal shares. Except that if any child of the Insured has not attained the age of eighteen (18) years on the date of payment, then payment should be made to, as Custodian for each minor child under the Massachusetts Uniform Transfers to Minors Act, without any responsibility on the part of The Savings Bank Life Insurance Company of Massachusetts as to the application of such payment by the Custodian. A separate custodianship will be created for each minor child of the Insured then living. I hereby nominate as the Successor Custodian if the original Custodian is no longer living or is unable to serve as Custodian at the time payment(s) are made.

The Insured's current children are listed below. All subsequent children are to be included in equal shares. All proceeds will be paid equally or the whole to the survivor.

Child's Name and Sex:	Birth Date:
<i>Any Name and Sex</i>	<i>Any Date</i>

All decisions made by SBLI in good faith as to the identity of the beneficiaries not designated by name shall be conclusive as to SBLI's liability and any payment made in accordance therewith shall, to the extent thereof, discharge SBLI of its obligation for such payment.

Please Sign Here:

9/1/2008
 Date

John A. Doe
 Signature of Proposed Insured
 (if age 15 or over)

 Signature of Applicant, if other than the
 Proposed Insured

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Question #19: Owner

Any Owner

Question #20: Beneficiary

Any Beneficiary

All decisions made by SBLI in good faith as to the identity of the beneficiaries not designated by name shall be conclusive as to SBLI's liability and any payment made in accordance therewith shall, to the extent thereof, discharge SBLI of its obligation for such payment.

Please Sign Here:

9/1/2008

Date

John A. Doe

Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

Date

Signature of Owner, if other than the
Proposed Insured

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
John A. Doe	9/1/2008	12345

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Question #20: Beneficiary

The net proceeds under each of the policies herein applied for shall be paid to ANY NAME as Trustee(s) or such Trustee(s) successor or successors, under the ANY TRUST Indenture of Trust dated ANY DATE without responsibility on the part of The Savings Bank Life Insurance Company of Massachusetts as to the application of the said proceeds by such Trustee(s). If the said Indenture of Trust is then terminated, the said proceeds shall be paid to the Owner or the Estate of the Owner.

Trustee's/Owner's Signature(s): Trustee Signature

Trust Tax Identification Number: Trust - Any Tax I.D.

Please Sign Here:

9/1/2008
Date
John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the Proposed Insured

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number;
John A. Doe	9/1/2008	12345

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Question #19: Owner

Any Trustee(s) as Trustee(s) or said Trustee(s) successor or successors, under the ANY TRUST Indenture of Trust dated ANY DATE.

Question #20: Beneficiary

The net proceeds under each of the policies herein applied for shall be paid to ANY Trustee(s) as Trustee(s) or such Trustee(s) successor or successors, under the ANY TRUST Indenture of Trust dated ANY DATE without responsibility on the part of The Savings Bank Life Insurance Company of Massachusetts as to the application of the said proceeds by such Trustee(s). If the said Indenture of Trust is then terminated, the said proceeds shall be paid to the Owner or the Estate of the Owner.

Trustee's/Owner's Signature(s): Trustee Signature

Trust Tax Identification Number: Trust - Any Tax ID.

Please Sign Here:

9/1/2008
Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Application Amendment
 Please Read Carefully and Sign Below
Avocation and Professional Sports Questionnaire

Proposed Insured	Application Dated	Policy Number
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Check "Yes" for all appropriate Avocations and Professional Sports Activities in which you participate and corresponding time frames.

Yes	Activity	Past 12 months and/or currently	Next 12 months and/or currently
	Aquascooters		
	Balloonists		
	Bicycle Riders (indicate in "Remarks" whether Sprint, Pursuit, or Motor Pace)		
	Boatload		
	Bobsled Racers (2 and 4 Man)		
	Boxers and Prizefighters (Professional)		
	Canoe and Kayak Competitors - Tobogganers, Sledders		
	Canoe and Kayak Competitors - White Water Slalom, Downriver		
	Cliff Divers - International Competitors and Professionals		
	Cliff Divers - Others (give details in "Remarks")		
	Dune Scooters		
	Hang Balloonists		
	Horse Racers & Competitors - Harness Racing Drivers (Pacing and Trotting)		
	Horse Racers & Competitors - Jockeys		
	Horse Racers & Competitors - Steeplechase Riders		
	Hunters - Big Game (give details in "Remarks")		
	Kiters		
	Laserteers		
	Luge Racers (1 and 2 Man)		
	Motorboard Surfers		
	Mountain Climbers		
	North American Continent - Rock Climbers		
	North American Continent - Trail Climbers		
	Elsewhere - Rock Climbers		
	Elsewhere - Trail Climbers		
	Para-Gliders		
	Para-Kiters		

THE SAVINGS BANK LIFE INSURANCE COMPANY OF MASSACHUSETTS (SBLI)

One Linscott Road, Woburn, MA 01801 800-694-7254

Avocation and Professional Sports Questionnaire - continued

Yes	Activity	Past 12 months and/or currently	Next 12 months and/or currently
	Para-Sailors		
	Para-SCUBA		
	Power Skiers		
	Rocketeers		
	Experimental metal rockets using home-mixed propellents		
	Rodeo - Clowns (Professional)		
	Rodeo - Performers - Amateur		
	Rodeo - Performers - Professional		
	Sand Surfers		
	Sand yacht Racers		
	Skiers - Acrobats		
	Skiers - Ski Jumpers, Downhill racers		
	Skydivers and Sport Parachutists - Amateur		
	Skydivers and Sport Parachutists - Professional		
	Affiliated with Parachute Club		
	Not Affiliated with Parachute Club		
	Spelunkers (Members of Search and Rescue Units)		
	Surfers - International Competitors and Professionals		
	Surfers - Others		
	Target Divers - International Competitors and Professionals		
	Target Divers - Others		
	Water Kites		
	Water Skiers - International Competitors and Professionals		
	Water Skiers - Water Ski Racing		
	Water Skiers - Water Speed Records		
	Wrestlers		

Remarks: _____

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9/1/2008  _____
 Date Signature of Proposed Insured -

Application Amendment

Please Read Carefully and Sign Below

Proposed Insured:	Application Dated:	Policy Number:
<i>John A. Doe</i>	<i>9/1/2008</i>	<i>12345</i>

I hereby request that the application on the life of the proposed insured be amended to read as follows:

Question #17: Have you ever used any form of tobacco or any other nicotine product or by-product?
 Yes No (If "Yes", provide details.)

I understand that, if my application is accepted, it may be approved on the condition that I pay each annual premium as may become due at Nicotine rates per \$1,000 of insurance at the insured's actual age nearest birthday. I agree that if the policy applied for, or any Insured Rider which may be attached to the policy, provides for convertible term insurance, the annual premium otherwise payable on a new policy as a result of any such conversion will be at Nicotine rates.

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that SBLI, believing them to be complete, correct and true, shall rely on them. I agree that they shall be a part of my application for insurance or policy change request.

Please Sign Here:

9-1-2008

Date

John A. Doe
Signature of Proposed Insured
(if age 15 or over)

Signature of Applicant, if other than the
Proposed Insured

SERFF Tracking Number: SBMS-125795100

State: Arkansas

Filing Company: SBLI of MA

State Tracking Number: 40288

Company Tracking Number: 2008003AAR

TOI: L071 Individual Life - Whole

Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Applications for Life Insurance

Project Name/Number: /2008003

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: SBMS-125795100 State: Arkansas
Filing Company: SBLI of MA State Tracking Number: 40288
Company Tracking Number: 2008003AAR
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Applications for Life Insurance
Project Name/Number: /2008003

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 08/28/2008

Comments:

Rule & Regulation 19: N/A This form filing is for the application and associated forms to be used in applying for the policies being submitted this date under separate filing.

Rule and Regulation 49: N/A This form filing is for the application and associated forms to be used in applying for the policies being submitted this date under separate filing.

Flesch Certification: Documet Attached

ACA 23-79-138: N/A This form filing is for the application and associated forms to be used in applying for the policies being submitted this date under separate filing.

Attachment:

Readability Certification.pdf

READABILITY CERTIFICATION

Company Name: The Savings Bank Life Insurance Company of Massachusetts

I hereby certify that the forms listed below have the following readability scores as calculated by the Flesch Reading Ease Test.

<u>Form Number</u>	<u>Form Name</u>	<u>Score</u>
A-90	Conditional Receipt Agreement	50 *
A-91	Life Insurance Application – Part 1	50 *
A-91A	Supplement to Life Insurance Application – Part 1	50 *
A-92	Life Insurance Application – Part 2	50 *
A-92A	Supplement to Life Insurance Application – Part 2	50 *
A-93	Supplement to Life Insurance Application	50 *
AQ-8	General Aviation Questionnaire	50 *
AQ-9	Commercial Aviation Questionnaire	50 *
AQ-10	Alcohol Questionnaire	50 *
AQ-11	Allergies Questionnaire	50 *
AQ-12	Asthma Questionnaire	50 *
AQ-13	Chest Pain Questionnaire	50 *
AQ-14	Diabetes Questionnaire	50 *
AQ-15	General Medical Questionnaire	50 *
AQ-16	Kidney Stones Questionnaire	50 *
AQ-17	Mental Health Questionnaire	50 *
AQ-18	Seizures Questionnaire	50 *
AQ-19	Colitis Questionnaire	50 *
AQ-20	Drugs Questionnaire	50 *
AQ-21	DUI Questionnaire	50 *
AQ-22	Skin and SCUBA and Submersible Diving Questionnaire	50 *

AQ-23	Substance Abuse Questionnaire (alcohol and drugs)	50 *
AQ-24	Military Status Questionnaire	50 *
AQ-25	Military Aviation Questionnaire	50 *
AQ-26	Avocation and Professional Sports Questionnaire	50 *
AQ-27	Hang Gliding Questionnaire	50 *
AQ-28	Motor Sports Questionnaire	50 *
AQ-29	Power and Motor Boat Questionnaire	50 *
AQ-30	Unemployment Questionnaire	50 *
AQ-31	Citizenship Questionnaire	50 *
AQ-32	General Amendment	50 *
AM-5	Updated Health Amendment	50 *
AM-16A	Agents Replacement Certification	50 *
AM-19M	Children under UTMA as Beneficiary	50 *
AM-19MS	Spouse, then Children under UTMA as Beneficiary	50 *
AM-20	Owner/Beneficiary	50 *
AM-20B	Trust, then Estate as Beneficiary	50 *
AM-20T	Trust as Owner	50 *
AM-20BT	Trust as Beneficiary and Owner	50 *
AM-26	Financial Disclosure Amendment	50 *
AM-28	Nicotine Amendment	50 *

* Forms accomplish a score of 50+ when combined with the base policy forms.


James Coady, V.P., Compliance
SBLI of MA


Date

<i>SERFF Tracking Number:</i>	<i>SBMS-125795100</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>SBLI of MA</i>	<i>State Tracking Number:</i>	<i>40288</i>
<i>Company Tracking Number:</i>	<i>2008003AAR</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Applications for Life Insurance</i>		
<i>Project Name/Number:</i>	<i>/2008003</i>		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Life Insurance Application – Part 1	08/29/2008	A-91.pdf

The Savings Bank Life Insurance Company of Massachusetts
P.O. Box 4048, Woburn, MA 01888
Telephone (800) 694-7254 www.sbli.com

In this application, "You" and "Your" refer to the Proposed Insured.

A. PRODUCT INFORMATION

1. Product <input checked="" type="checkbox"/> Level Term: <input type="checkbox"/> 10Yr <input type="checkbox"/> 15Yr <input checked="" type="checkbox"/> 20Yr <input type="checkbox"/> 25Yr <input type="checkbox"/> 30Yr <input type="checkbox"/> Whole Life: <input type="checkbox"/> SL <input type="checkbox"/> L10 <input type="checkbox"/> L15 <input type="checkbox"/> L20 <input type="checkbox"/> L@65 <input type="checkbox"/> SPL <input type="checkbox"/> YRT <input type="checkbox"/> Other _____	2. Face Amount \$100,000	3. Riders/Additional Benefits <input type="checkbox"/> Term Insurance Rider Plan _____ \$ _____ <input type="checkbox"/> Child Insurance Rider \$ _____ <input type="checkbox"/> Waiver of Premium Rider <input type="checkbox"/> Other: _____	4. Location of Sale (city, state) Any City, State
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B. PROPOSED INSURED INFORMATION

1. Full Name (First, Middle, Last. Include maiden name) John A. Doe	2. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth (mm/dd/yyyy) 1/1/1970	4. Birth State & Country Any State, Country	5. SSN 123456789
6. Home Address (Number, Street, City, State, Zip Code) 123 ANY street Any City, State 98765	7. Phone and Email: Home #: 123-456-7990 Cell#: _____ Work#: _____ Email: _____ Preferred method of contact: _____			
8. Driver's License Number 12345 State Issued: ANY state	9. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Single <input type="checkbox"/> Widowed # of dependents: 0 Ages: _____	10. U.S. Citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If "No", complete the Citizen Questionnaire and attach copy of green card or visa)		
11. Occupation (include duties) Any Occupation	12. Employer Name and Address Any Employer, Any City, Any State	13. How long employed? 10 Years		
14. Have you ever used tobacco or any other nicotine product or by-product of any type? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes"; Type: _____ How long used: _____ Last used: (mm/yyyy) _____ Amount & Frequency: _____				
15. How much life insurance does your spouse have in force with all insurers, including SBLI? \$ 0 Is your spouse also applying for insurance with SBLI? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", how much? \$ N/A				

C. OWNER/APPLICANT INFORMATION Complete only if Owner is to be other than the Proposed Insured. If Trust, give full name of Trust and date of Trust agreement.

1. Type: <input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Other (Specify): _____				
2. Owner/Applicant/Trust Name	3. Date of Birth/Trust (mm/dd/yyyy)	4. Relationship to You	5. SSN/TIN	
6. Residence Address (Number, Street, City, State, Zip Code)	7. Email	8. Phone Numbers:		
9. Billing Address (Number, Street, City, State, Zip Code)	10. State Incorporated	11. Purpose of Trust		
12. Trust Contact Name	13. Type of Trust <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	14. Name of Trustee(s)/Corporate Officer		
15. Does the above Trustee have sole authority to act on behalf of the Trust? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", list the names and addresses of all Trustees and obtain their signatures below. Attach a separate page, if necessary.)				
Trustee's Name	Address	Signature		

John A. Doe

Name of Proposed Insured

D. BENEFICIARY INFORMATION If percentages are not given, shares will be distributed equally. Total percentage of primary beneficiaries' shares must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Attach separate sheet for additional beneficiaries.

1. Primary Beneficiaries

Table with 6 columns: Full Name, Address, Date of Birth, SSN or TIN, Relationship to You, % Share. Row 1: Jane Doe, 123 Any Street, City, State, 1/1/1970, 987654321, sister, 100.

2. Contingent Beneficiaries

Table with 6 columns: Full Name, Address, Date of Birth, SSN or TIN, Relationship to You, % Share. All fields are empty.

3. If the beneficiary is a Trust or Corporation, provide name and date created:

Table with 4 columns: Name of Trust/Corporation, List Trustees if applicable, Date of Trust, State Incorporated. All fields are empty.

E. PROPOSED INSURED INSURANCE NEEDS Complete either the Personal or Business Section. Explain "Yes" answers in the Remarks Section.

Personal Section

1. Purpose of Insurance: [X] Income Replacement [] Debt Repayment [] Estate Conservation [] Other (Specify):
2. Gross Annual Income \$ 50,000
3. Household Income \$ 50,000
4. Net Worth \$ 100,000
5. Within the last 5 years, have you filed for bankruptcy or had any judgments or liens filed against you? [] Yes (Date of Discharge:) [X] No

Business Section

6. Purpose of Insurance: [] Buy-Sell [] Key Employee [] Secure Credit [] Other (Specify):
7. Is the business a: [] Corporation [] Partnership [] Proprietorship [] Other
8. Type of Business
9. How long has the business been established?
10. Total Liabilities \$
11. Net Worth \$
12. Within the last 5 years, has the business filed for bankruptcy or had any judgments or liens filed against it? [] Yes (Date of Discharge) [] No
13. Net Profit after taxes for the past two years: Last Year: \$ Previous Year: \$
14. What % of the business is owned by you?
15. Your gross annual income with bonuses: \$
16. Amount of business insurance in force on your life: \$

17. In the Remarks section (J):

- a. If applicable, describe any insurance being applied for or in force on other key members of the business.
b. If applicable, describe why there is no insurance being applied for or in force on other key members of the business.

F. PROPOSED INSURED PERSONAL HISTORY

- 1. Have you ever sold a policy or been involved in any discussions about the possible sale or assignment of this policy to a life settlement, viatical or other secondary market Provider/Producer? (If "Yes", provide details below) [] Yes [X] No
2. Do you have any other applications or informal inquiries for life insurance pending with any other company, society or association in the last 12 months? (If "Yes", provide details below) [] Yes [X] No
3. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited, withdrawn, or cancelled, or have you been asked to pay a higher premium? (If "Yes", provide details below) [] Yes [X] No
4. Have you, in the last 3 years, resided or traveled, or do you intend to reside or travel, outside of the United States? (If "Yes", complete the Foreign Travel Questionnaire) [] Yes [X] No
5. In the last 3 years, has your driver's license been suspended or revoked, or have you received any moving violations? (If "Yes", provide details below) [] Yes [X] No

John A. Doe

Name of Proposed Insured

- 6. Have you ever been convicted of reckless driving, driving to endanger or driving under the influence of drugs or alcohol? (If "Yes", provide details below)..... Yes No
- 7. Except for traffic violations, have you been the subject of, or been convicted of, a misdemeanor or felony, or are you awaiting trial for a felony? (If "Yes", provide details below)..... Yes No
- 8. Have you in the last 3 years engaged in, or do you intend to engage in, flying a plane, racing motor boats or motor vehicles, or participate in sky-diving or parachuting, hang-gliding, hot air ballooning, mountain, rock or ice climbing, scuba diving or other hazardous activities? (If "Yes", complete the appropriate Hazardous Activities and/or Aviation Questionnaire) Yes No
- 9. Are you currently or intend to become a member of the Armed Forces, including the Reserves or National Guard? (If "Yes", complete the Military Questionnaire)..... Yes No

For any "Yes" answers, record details below: Use the overflow sheet if needed.

Question #	Explanation

G. PREMIUM PAYMENT INFORMATION (If "EFT" or "Credit Card", please fill in the EFT or Credit Card form. Credit Card available only for Initial Payment)

1. Initial Payment: <input checked="" type="checkbox"/> Check <input type="checkbox"/> COD <input type="checkbox"/> Credit Card <input type="checkbox"/> Electronic Fund Transfer (EFT) <input type="checkbox"/> Other (Specify):	2. Payment Mode: <input checked="" type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (EFT only)	3. Send Premium Notices to: <input checked="" type="checkbox"/> Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (Specify):
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4. Amount paid with Conditional Receipt Agreement (CRA): \$ 100.00	5. Would you like to backdate your policy to save age? (If "Yes", see Backdating Disclosure section in the Notice to Proposed Insured and Owner)..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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H. DIVIDEND OPTIONS (If this section is left blank or a selected option is not available, the default option will be Accumulate at Interest)

- 1. Pay in Cash (check)
- 2. Reduce amount due – any excess as: #4 #3 #1
- 3. Purchase Paid Up Life Additions
- 4. Accumulate at interest

I. REPLACEMENT INFORMATION Applies to both Owner and Proposed Insured.

If you intend to replace existing coverage, please tell the Producer of your intention and answer "Yes" to replacement question #2 below. State law may require the Producer to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain, among other things, new suicide exclusions and contestability periods. Ask the Producer if you are unsure.

	Proposed Insured	Owner
1. Do you have an existing or pending life insurance policy or annuity contract? (If "Yes", provide details below. Complete state required replacement form for New NAIC Model Replacement Regulation States only)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you intend to replace any existing life insurance or annuity contract? (If "Yes", complete state required replacement form and provide details below)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you considering using funds from an existing policy or contract to pay premiums on the policy you are applying for? (If "Yes", complete state required replacement form and provide details below)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you stopped making premium payments, surrendered, forfeited, assigned to the Company, or otherwise terminated an existing policy or contract or are you considering doing so? (If "Yes", complete state required replacement form and provide details below)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Insurance Companies (Do not include group policies)	Name of Insured	To be replaced?	Contract / Policy #	Cash Value / Amount of Coverage	Date Issued
		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	

J. REMARKS (Use this section for explanations and special requests. Identify applicable Question and Section numbers.)

John A. Doe

Name of Proposed Insured

K. AUTHORIZATION TO COLLECT AND DISCLOSE INFORMATION

This Authorization complies with the Health Insurance Portability and Accountability Act ("HIPAA")

I hereby authorize all the entities listed below that have provided payments, treatments or services to me, or on my behalf, to disclose to The Savings Bank Life Insurance Company of Massachusetts (the "Company") and its Producers, employees and representatives, including insurance support organizations, the following information: any and all information relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of alcohol, drugs, and tobacco; drug prescriptions and communicable diseases, including Human Immunodeficiency Virus (HIV) and AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner or health care professional;
- any hospital, laboratory, pharmacy, pharmacy benefit manager, clinic or other health care facility or provider;
- any insurance or reinsurance company;
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB)

This protected health information may be disclosed pursuant to this Authorization so that the Company can use it to:

- determine my eligibility for insurance;
 - underwrite my application and make risk rating, policy issuance and enrollment determinations;
 - determine my eligibility for benefits under the Conditional Receipt Agreement;
 - obtain reinsurance;
 - if a policy is issued, administer coverage, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and
 - conduct other legally permissible activities that relate to any insurance coverage I have or have applied for with the Company.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, medical practitioner, health care provider, hospital, clinic or any other health care provider to release and disclose my entire medical record without restriction. I understand that my health care providers can not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.
 - I further authorize the Company to release any information obtained by this Authorization to MIB, to other insurers in which I have policies or to which I may apply or to which a claim for benefits may be submitted, to reinsurers, and to other persons or organizations performing legal or business services in connection with my application or claim. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.
 - I authorize the Company to release to me, or to my physician, results that I may request of any medical or laboratory tests taken in connection with this application. In connection with a claim for benefits, this Authorization is valid no longer than the duration of the claim.
 - I also understand that failure to sign this Authorization statement, or subsequent revocation of this Authorization by me, may impair the ability of the Company to process my application or evaluate claims, and may be a basis for denying an application or claim for benefits.
 - By signing below I agree to the terms of this Authorization and acknowledge that I have read and understand it.

FOR MAINE and VERMONT APPLICANTS, this Authorization excludes the release of any information relating to previously administered test for HIV antibodies, T-Cell counts, AIDS or ARC, by the applicants family/regular/attending medical doctor/physician/practitioner or care giver or any other person or entity which may possess this information. This exclusion extends 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 companies, or anyone else with respect to previous test results. The applicant is not authorizing the Company to forward the results from any new test, requested of the applicant by the Company to an outside, non-affiliated company, nor to any entity not under specific contract with the Company to perform underwriting services.

I may revoke this Authorization in writing at any time, except to the extent that action has been taken in reliance of this Authorization or to the extent the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself, by sending a written request to: The Savings Bank Life Insurance Company, P.O. Box 4048, Woburn, MA 01888. I understand that any information that is disclosed prior pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

This Authorization shall remain in force for 24 months following the date of my signature below or for the duration of any claim for benefits. A copy of this Authorization is as valid as the original. I understand that if I refuse to sign this Authorization to release my complete medical information, the Company may not be able to process my Application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

Date: 9/1/2008 Signature of Proposed Insured (Parent, Guardian, Other*): John A. Doe

*If the insured is under the age of 18, signature of Parent Guardian Other:

John A. Doe

Name of Proposed Insured

L. FRAUD WARNINGS

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or Producer of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information, is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and maybe subject to fines and confinement in prison.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person, who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio and Oregon: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer and/or insurance company, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance company containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

M. REPRESENTATIONS

I, the Owner and the Proposed Insured signing below, agree that I have read the statements contained in the application or they have been read to me. I understand that the application includes the Application – Parts I and II and all supplemental forms or amendments the Company specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner.

I acknowledge that my answers to the above questions may result in higher premium rates or a denial in coverage.

I understand and agree that no Producer is authorized to (a) accept risks or pass upon insurability; (b) make or modify contracts; (c) waive the Company's rights or requirements; or (d) waive any information the Company requests.

I represent: (1) that the statements and answers I provided within the entire application are true, complete, and correct to the best of my knowledge and belief; (2) that the Company, believing the statements and answers to be true, complete, and correct, shall rely and act on them (3) the insurance being applied for is suitable for the Owner's insurance needs.

Under penalty of perjury, I certify that : a) the number shown is my correct taxpayer identification number and b) I am not subject to backup withholding because 1) I am exempt from backup withholding, or 2) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or 3) the IRS has notified me that I am no longer subject to backup withholding. The IRS does not require your consent to any provision of this document other than certification required to avoid backup withholding.

CROSS OUT ALL OF SUBPART "b)" IN THE PRECEDING PARAGRAPH IF YOU ARE SUBJECT TO BACKUP WITHHOLDING.

John A. Doe
Name of Proposed Insured

I acknowledge that I have received a copy or I have been read a copy of the Notice to Proposed Insured and Owner.

I agree that:

(a) I will notify the Company if any statement or answer given in the entire application changes prior to policy delivery; and
(b) except as provided in the Conditional Receipt Agreement (CRA), I understand and agree that even if I paid a premium, no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless the following three conditions are all met:

- (1) the policy has been delivered and accepted;
- (2) the full first modal premium for the delivered policy has been paid in full; and
- (3) there has been no change in the health of the Proposed Insured that would change the answers to any questions in the application, or any amendments thereto, before conditions (1) and (2) above have occurred.

I understand and agree that if all three conditions are not met:

- no insurance coverage will become effective; and
- the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

Signature of Proposed Insured <u>John A. Doe</u>		Date <u>9/1/2008</u>	Signature of Owner/Applicant (if not Proposed Insured)		Date
Signature of Producer <u>Any Producer</u>		Date <u>9/1/2008</u>	Signature of Producer		Date
Producer Name Printed <u>Any Producer</u>			Producer Name Printed		
SSN <u>333222111</u>	License # <u>01234</u>	Producer # <u>56789</u>	SSN	License #	Producer #
Rate applied for: <u>Standard Non-Nicotine</u>					

The Company reserves the right to make administrative changes to the application. No administrative changes will be ascribed to the applicant.

N. PRODUCER INFORMATION and PRODUCER CERTIFICATION

1. Does the Applicant have existing life insurance policies or annuity contracts? Yes (Submit the state applicable replacement form) 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 applied for policy? Yes No
3. Do you have any knowledge or reason to believe that the proposed Owner or Applicant intends to change ownership of the policy now or in the future to an unrelated party such as a trust, viatical, life settlement company, bank and/or lending or investment company? Yes No
4. Do you have any knowledge or reason to believe that all or any part of the initial or future premium payments for this applied for policy may be directly or indirectly financed by an unrelated third party or be part of any loan arrangement? Yes No
5. Do you have any knowledge or reason to believe that the proposed Owner, Applicant or Insured has been offered any financial incentives as an inducement to apply for this proposed policy? Yes No
6. Have you received relevant anti-money laundering training within the last 24 months that was offered by the company, another life insurance company or a competent third party (e.g., LIMRA)? Yes No
7. Do you acknowledge that you are in compliance with your requirements as stated in the company's Producer's Guide to Anti-Money Laundering (AML) and are unaware of any AML Red Flags as described in your AML training? Yes No

I certify that the responses herein are, to the best of my knowledge, information and belief complete and accurate.

I certify that this policy has not been solicited, directly or indirectly for the benefit of an investor, stranger or unrelated third party.

I certify that I am duly licensed in the state in which this application was signed.

I have given the Proposed Insured the appropriate disclosure documents and have complied with state and federal statutes and regulations.

I have reviewed the purchase of the life insurance policy as to suitability.

Any Producer
(Producer's Signature)

Any Producer
(Producer's Printed Name)

9-1-2008
(Date)

Lead #:
Source:
Rate Code:
Process Date:

Underwriting Stamp