

SERFF Tracking Number: BSTN-125799799 State: Arkansas
 Filing Company: Boston Mutual Life Ins Co State Tracking Number: 40161
 Company Tracking Number: GRP-08-005
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
 Product Name: Group Combined Master Application
 Project Name/Number: Group Life and Health Combined Master Application/GRP-08-005

Filing at a Glance

Company: Boston Mutual Life Ins Co
 Product Name: Group Combined Master Application SERFF Tr Num: BSTN-125799799 State: ArkansasLH
 TOI: L04G Group Life - Term SERFF Status: Closed State Tr Num: 40161
 Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium Co Tr Num: GRP-08-005 State Status: Approved-Closed
 Filing Type: Form Co Status: Reviewer(s): Linda Bird
 Authors: Peggy Schwartz, Karen Thurston Disposition Date: 09/10/2008
 Date Submitted: 09/04/2008 Disposition Status: Approved
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: Group Life and Health Combined Master Application Status of Filing in Domicile: Pending
 Project Number: GRP-08-005 Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Small and Large
 Overall Rate Impact: Group Market Type: Other
 Filing Status Changed: 09/10/2008
 State Status Changed: 09/10/2008 Deemer Date:
 Corresponding Filing Tracking Number:
 Filing Description:
 Enclosed for your approval is Group life and disability application GROUP APP 08/08 to be used with the following previously approved forms:

- Group Life Policy: GRTP (4/99) approved in Arkansas on 06/13/00 and
- Group Disability Income policy GDP100 approved in Arkansas on 11/06/96

<i>SERFF Tracking Number:</i>	<i>BSTN-125799799</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Boston Mutual Life Ins Co</i>	<i>State Tracking Number:</i>	<i>40161</i>
<i>Company Tracking Number:</i>	<i>GRP-08-005</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Group Combined Master Application</i>		
<i>Project Name/Number:</i>	<i>Group Life and Health Combined Master Application/GRP-08-005</i>		

A list of the approval information for these forms is included in this filing under supporting documentation.

This master application is a new form and does not replace any existing forms. It is used to market life and disability coverage in the employer Group market by licensed agents and brokers. It is a combination master application form that will simplify the employer's application process.

This form does not contain any unusual or controversial items from normal company standards and is in compliance with the laws and regulations of your state. It is written in readable language that meets your minimum Flesch score requirements. A certification of readability is enclosed in this filing.

Massachusetts, our domiciliary state, does not require the submittal of health filings as stated in Chapter 175, Section 110 of the Massachusetts General Laws. The application is currently pending review by the Massachusetts life form review section.

Company and Contact

Filing Contact Information

Karen Thurston, Legal/Compliance Analyst	karen_thurston@bostonmutual.com
Compliance Dept	(781) 770-0430 [Phone]
Canton, MA 02021	(781) 770-0490[FAX]

Filing Company Information

Boston Mutual Life Ins Co	CoCode: 61476	State of Domicile: Massachusetts
120 Royall Street	Group Code: 581	Company Type:
Canton, MA 02021	Group Name:	State ID Number:
(781) 770-0423 ext. [Phone]	FEIN Number: 04-1106240	

Filing Fees

Fee Required?	Yes
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Product Name: *Group Combined Master Application*
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Fee Amount: **\$75.00**
Retaliatory? **Yes**
Fee Explanation: **Retaliatory fee. \$75.00 per filing.**
Per Company: **No**

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Boston Mutual Life Ins Co	\$75.00	09/04/2008	22277689

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	09/10/2008	09/10/2008

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Disposition

Disposition Date: 09/10/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Fraud Warnings		Yes
Supporting Document	Flesch Score Certification		Yes
Supporting Document	Cover letter		Yes
Form	Group Combined Master Application		Yes

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Form Schedule

Lead Form Number: GROUP APP 08/08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GROUP APP 08/08	Application/Group Combined Enrollment Form	Master Application	Initial		50	GroupLifeHealthApp.pdf

APPLICATION FOR GROUP INSURANCE

120 ROYALL STREET • CANTON MA 02021



GROUP POLICY NO: _____

1. Legal Name of Applicant: _____ the Policyholder

2. Requested Effective Date: _____

3. Applicant is a: Corporation Partnership Proprietorship Trusteeship Association SubchapterS Government Entity

4. Nature of Business: _____

5. Subsidiary or Affiliated Companies to be covered. (In case of trusteeship or association, attach contributing Employers/Members):

Name	Address	Relationship to Applicant	Subsidiary or Affiliate

6. Address: _____
Street City State Zip

7. Billing Address: _____
(if different than above) Street City State Zip

8. Primary Contact Name: _____ Title: _____

9. Telephone: _____ Fax: _____ Email: _____

10. Premiums will be paid _____ day of the month according to the following schedule: Monthly Quarterly Semi-Annually Annually

11. Initial Deposit Amount: \$ _____

12. Requested Coverages: Group Life - Including Waiver of Premium Yes No Group Short Term Disability
 Group Accidental Death & Dismemberment 24 Hour Group Long Term Disability

13. Does this requested coverage replace existing insurance? Yes No If yes, please specify each coverage and insurance carrier below:

Employee Class	Type/Amount of Coverage	Insurance Carrier	Effective Date	Termination Date

14. Continuity of Coverage for LTD: Yes No (if yes, attach copy of prior carrier's booklet) Termination Date: _____

15. a. Total Eligible Employees _____. b. Employees must work a minimum of _____ regularly scheduled hours per week.

16. Waiting Period for Eligible Employees:

Employee Class and/or Coverage	New Employees	Current Employees	Effective 1 st of the Month Following Yes/No

A person must be Actively at Work as of the effective date of this policy and on their eligibility date to be covered for insurance requested.
 If a person is not Actively At Work coverage will not become effective until he/she is returned to active employment.

17. Changes in employee's insurance shall become effective: on the 1st day of the insurance month next following date of change
 upon the anniversary date of the group policy
 other please specify _____

18. If applicable, name and address of Third Party Administrator: _____

19. Is Boston Mutual preparing W-2 Forms for employees receiving disability benefits under this policy: a. Short Term Disability Yes No
b. Long Term Disability Yes No

PLEASE NOTE:

- A separate election must be authorized for each unique group policy and division thereof.
- Having Boston Mutual prepare your W-2 forms for your employees receiving disability benefits does not release you of your obligation to file a "Third-Party Sick Pay Recap" W2 and W-3 form. These recap forms are needed to reconcile employer match of FICA you have paid in on behalf of your employees.
- If you request that Boston Mutual Life prepare your W-2 forms for third party sick pay benefits paid to your employees, you agree that such forms will be prepared using Boston Mutual Life's name and employer identification number or its Third party vendor.
- This election will remain in effect until amended or canceled in writing.

COMMENTS - SPECIAL REQUESTS:

IT IS UNDERSTOOD AND AGREED THAT:

1. THE GROUP INSURANCE WILL BECOME EFFECTIVE ON THE DATE REQUESTED ONLY IF THIS APPLICATION IS ACCEPTED AT THE HOME OFFICE OF BOSTON MUTUAL LIFE INSURANCE COMPANY IN CANTON, MASSACHUSETTS;
2. THE CONDITIONS OF ELIGIBILITY, THE CONDITIONS UNDER WHICH INSURANCE FOR ANY PERSON BEGINS AND ENDS, THE INSURANCE COVERAGE, BENEFITS AND AMOUNTS, THE CONDITIONS UNDER WHICH THE BENEFITS WILL BE PAYABLE, AND OTHER TERMS AND CONDITIONS WILL BE IN ACCORDANCE WITH THE POLICY(IES) ISSUED AND ANY AMENDMENTS, RIDERS, OR ENDORSEMENTS THERETO; AND
3. THE POLICY(IES) ISSUED AND ANY AMENDMENTS, RIDERS, EXHIBITS OR ENDORSEMENTS THERETO, TOGETHER WITH THE COPY OF THIS APPLICATION, SCHEDULE OF BENEFITS AND COST EXHIBIT TO BE ATTACHED TO THE POLICY(IES) AND THE INDIVIDUAL APPLICATIONS, IF ANY, OF THE PERSONS TO BE INSURED, WILL CONSTITUTE THE ENTIRE CONTRACT.

Dated at: _____
City, State

Month - Day - Year

Licensed Agent/Agency Name (print)

Full Name of Applicant's Authorized Representative (print)

Signature of Agent or Authorized Agency Representative

Signature of Applicant's Authorized Representative

SSN/TIN

National Producer Number

Title of Applicant's Authorized Representative (print)

PLEASE READ THE ATTACHED FRAUD WARNINGS

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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 09/02/2008

Comments:

Attahced is the signed Compliance Certification.

Attachment:

ArkansasCompCertGroup.pdf

Review Status:

Satisfied -Name: Fraud Warnings 09/02/2008

Comments:

Attached are the Fraud Warnings that will accompany the application included in this filing.

Attachment:

GroupLifeHealthFraudWarn.pdf

Review Status:

Satisfied -Name: Flesch Score Certification 09/02/2008

Comments:

Attached is the Flesch Score Certificaiton.

Attachment:

GroupLifeHealthFlesch.pdf

Review Status:

Satisfied -Name: Cover letter 09/02/2008

Comments:

Attached is the Cover Letter.

Attachment:

GroupLifeHealthCoverLetter.pdf



ARKANSAS COMPLIANCE CERTIFICATION

Group Life and Health Combined Master Application

FORM NUMBER(S): GROUP APP 08/08

Having carefully reviewed the above numbered form(s), I hereby certify, to the best of my knowledge, information and ability, that:

1. Said form, listed above, and the previously filed and approved policies with which they will be used, conforms in all aspects to the provisions of the Arkansas Rule and Regulation 19, 49 and Consumer Notices, as well as all other applicable requirements of the Insurance Department of Arkansas;
2. Said form(s) contain no provision or provisions previously disapproved or called to our attention by the Insurance Department of Arkansas.

A handwritten signature in black ink that reads "Richard J. Miller". The signature is written in a cursive style.

Signed:

Richard J. Miller
Director, Contracts & Compliance

Date: September 03, 2008

BOSTON MUTUAL LIFE INSURANCE COMPANY

FRAUD WARNINGS

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.

California - For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 agent 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 – It is a crime to provide false or misleading information to any 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 an 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.

Maine - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company. Penalties include imprisonment, fines or a denial of insurance benefit.

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.

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

Oregon - Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Puerto Rico - Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years, if mitigating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia - 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 may have violated state law.

Washington - Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application of insurance may be guilty of a criminal offense under state law.



I certify to the best of my knowledge and belief that these forms are in compliance with the NAIC Model Act regarding Simplified and Readable Life Insurance Policies.

I also certify that the Flesch scores for the form(s) contained in this submission are as indicated below.

FORM #	FLESCH SCORE
GROUP APP 08/08	50.01

I also certify that these forms are printed in not less than 10 point type, one point leading.

A handwritten signature in cursive script that reads "Richard J. Miller".

Richard J. Miller
Director, Contracts & Compliance

Date: September 2, 2008



Peggy Schwartz, FLMI, ALHC, AIRC
Filing Manager

September 03, 2008

VIA SERFF

RE: NAIC # 61476 – FEIN # 04-1106240
Boston Mutual Life Insurance Company
Group Life and Disability Application
Form #: GROUP APP 08/08

Company Tracking # GRP-08-005

Enclosed for your approval is Group life and disability application GROUP APP 08/08 to be used with the following previously approved forms:

- Group Life Policy: GRTP (4/99) approved in Arkansas on 06/13/00 and
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Massachusetts, our domiciliary state, does not require the submittal of health filings as stated in Chapter 175, Section 110 of the Massachusetts General Laws. The application is currently pending review by the Massachusetts life form review section.

Please contact me if you need further information.

Sincerely

A handwritten signature in cursive script that reads "Peggy Schwartz".

Peggy Schwartz, FLMI, ALHC, AIRC
800 669 2668 Ext 423
Fax: 781 770 0490
marguerite_schwartz@bostonmutual.com