

SERFF Tracking Number: BSTN-127202820 State: Arkansas
Filing Company: Boston Mutual Life Insurance Company State Tracking Number: 49009
Company Tracking Number: IND-11-008
TOI: L07I Individual Life - Whole Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life
Product Name: General Agency Simplified Underwriting Application
Project Name/Number: GA SI Underwriting Application/IND-11-008

Filing at a Glance

Company: Boston Mutual Life Insurance Company

Product Name: General Agency Simplified Underwriting Application SERFF Tr Num: BSTN-127202820 State: Arkansas

TOI: L07I Individual Life - Whole SERFF Status: Closed-Approved- Closed State Tr Num: 49009

Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life Co Tr Num: IND-11-008 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird
Authors: Peggy Schwartz, Kathy Padis Disposition Date: 06/10/2011
Date Submitted: 06/07/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: GA SI Underwriting Application
Project Number: IND-11-008
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Kathy Padis

Filing Description:
RE: Boston Mutual Life Insurance Company
NAIC # 61476 FEIN #04-1106240
Individual Life Insurance Application Form:
Form #: NB1 SF/SD 4/11

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Filed concurrently in state of domicile.
Market Type: Individual
Individual Market Type:
Filing Status Changed: 06/10/2011
State Status Changed: 06/10/2011
Created By: Kathy Padis
Corresponding Filing Tracking Number: IND-11-008

<i>SERFF Tracking Number:</i>	<i>BSTN-127202820</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Boston Mutual Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>49009</i>
<i>Company Tracking Number:</i>	<i>IND-11-008</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>General Agency Simplified Underwriting Application</i>		
<i>Project Name/Number:</i>	<i>GA SI Underwriting Application/IND-11-008</i>		

Company Filing No. IND-11-008

We are submitting for approval the above application form. This is a new form and does not replace any existing form.

This is a simplified underwriting application which will be used by licensed independent agents and brokers in the individual life insurance market. It will be used to apply for both whole life and term life coverage under policy forms approved in your state.

The form does not contain any unusual or controversial items from the standpoint of normal company or industry standards. The form is in final print, 10-point type. It meets the minimum readability requirements of this state and a certification is included with this filing. To the best of our knowledge and belief, this submittal complies with the laws and regulations of your state.

DOMICILLIARY APPROVAL: This form was filed concurrently in Massachusetts our state of domicile.

Company and Contact

Filing Contact Information

Peggy Schwartz, Product Filing Manager	marguerite_schwartz@bostonmutual.com
120 Royall Street	781-770-0423 [Phone]
Canton, MA 02021	781-770-0490 [FAX]

Filing Company Information

Boston Mutual Life Insurance Company	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
Fee Amount:	\$75.00
Retaliatory?	Yes
Fee Explanation:	Massachusetts, our domicile state, would charge a \$75.00 fee for this filing. This is more than

SERFF Tracking Number: *BSTN-127202820* State: *Arkansas*
Filing Company: *Boston Mutual Life Insurance Company* State Tracking Number: *49009*
Company Tracking Number: *IND-11-008*
TOI: *L071 Individual Life - Whole* Sub-TOI: *L071.101 Fixed/Indeterminate Premium - Single Life*

Product Name: *General Agency Simplified Underwriting Application*

Project Name/Number: *GA SI Underwriting Application/IND-11-008*

the \$50.00 fee that Arkansas would charge so the \$75.00 is the fee charged.

Per Company: *No*

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Boston Mutual Life Insurance Company	\$75.00	06/07/2011	48429170

SERFF Tracking Number: BSTN-127202820 State: Arkansas
Filing Company: Boston Mutual Life Insurance Company State Tracking Number: 49009
Company Tracking Number: IND-11-008
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: General Agency Simplified Underwriting Application
Project Name/Number: GA SI Underwriting Application/IND-11-008

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/10/2011	06/10/2011

SERFF Tracking Number: *BSTN-127202820* *State:* *Arkansas*
Filing Company: *Boston Mutual Life Insurance Company* *State Tracking Number:* *49009*
Company Tracking Number: *IND-11-008*
TOI: *L071 Individual Life - Whole* *Sub-TOI:* *L071.101 Fixed/Indeterminate Premium - Single Life*

Product Name: *General Agency Simplified Underwriting Application*
Project Name/Number: *GA SI Underwriting Application/IND-11-008*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Form	Individual Life Application		Yes

SERFF Tracking Number: *BSTN-127202820* *State:* *Arkansas*
Filing Company: *Boston Mutual Life Insurance Company* *State Tracking Number:* *49009*
Company Tracking Number: *IND-11-008*
TOI: *L071 Individual Life - Whole* *Sub-TOI:* *L071.101 Fixed/Indeterminate Premium - Single Life*

Product Name: *General Agency Simplified Underwriting Application*
Project Name/Number: *GA SI Underwriting Application/IND-11-008*

Form Schedule

Lead Form Number: NB1 SF/SD 4/11

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	NB1 SF/SD 4/11	SF/SD Application/Individual Life Enrollment Form	Application	Initial		65.800	standard SF SD app for filing.pdf

BOSTON MUTUAL LIFE INSURANCE APPLICATION

120 ROYALL STREET · CANTON, MA 02021-9968
 NEW BUSINESS FAX #: 877-366-3036



1st AGENT	2nd AGENT
Agency # _____	_____
Payroll # _____	_____

1. Name of Primary Proposed Insured (Last, First, MI)		Maiden Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth <small>Month Day Year</small>	Age	Place of Birth
Residence Address of Primary Proposed Insured: No. & Street		City	State		Zip	
Communications Address (if other than residence address): No. & Street		City	State		Zip	
Telephone Numbers		Time to Call	E-Mail			
Day:	Evening:	Cell:				
Social Security Number	Occupation	Monthly Income	Marital Status	Height & Weight		
- -		\$	<input type="checkbox"/> married <input type="checkbox"/> single	___ ft. ___ in. - ___ lbs.		
Plan for all Proposed Insureds	Primary Insured's Amt.	Premium Amt.	Accidental Death Benefit	Waiver of Premium	APL	
	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No - Amt.\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name & Address of Primary Proposed Insured's Employer: No. & Street		City	State		Zip	

Is the Primary Insured actively at work? (at least 30 hours per week) Yes No If No, please explain:

Primary Beneficiary(ies) for Primary Proposed Insured	Address	Relationship to Primary Insured	% of Share	Age	Date of Birth	Date of Trust
Contingent Beneficiary(ies) for Primary Proposed Insured	Address	Relationship to Primary Insured	% of Share	Age	Date of Birth	Date of Trust

2. Name of Additional Proposed Insured		Relationship to Owner	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth <small>Month Day Year</small>	Age	APL <input type="checkbox"/> Yes <input type="checkbox"/> No
Place of Birth		Social Security Number	Height & Weight		Marital Status	
		- -	___ ft. ___ in. ___ lbs.		<input type="checkbox"/> Married <input type="checkbox"/> Single	
Amt. of Insurance	Premium Amt.	Beneficiary Name & Address		Age	Date of Birth	Relationship
\$	\$				<small>Month Day Year</small>	
WP <input type="checkbox"/> Y <input type="checkbox"/> N	ADB <input type="checkbox"/> Y <input type="checkbox"/> N - Amt. \$	Employer & Address		Occupation	Monthly Income	Actively at Work <input type="checkbox"/> Yes <input type="checkbox"/> No
Proposed Insured Address if different from Owner:		Telephone Numbers				
		Home:		Other:		

3. <input type="checkbox"/> Owner (Complete if other than Primary Proposed Insured)	Relationship	Owner SS #	Owner Phone #
Name:		- -	
Residence Address:			Owner's Date of Birth

4. <input type="checkbox"/> Payor (if other than Primary Proposed Insured)	Relationship	Payor's SS #	Payor's Phone #
Name:		- -	
Residence Address:			Payor's Date of Birth
Payor's Employer & Address: City	State	Zip	Monthly Income
			\$
	Payor's Occupation	Height & Weight (if covered)	
		___ ft. ___ in. - ___ lbs.	

Mode of Payment: Annual Semi-Annual Quarterly PAC Allotment * Salary Deduction *
 Total Premium paid with application \$ _____ * Frequency of deduction: Weekly Bi-Weekly Semi-Monthly Monthly
 Total Modal Premium \$ _____ + PDF Amount \$ _____ = Total \$ _____

5. Primary Supplementary Benefits and Riders - refer to Training & Procedures Manual for availability.			Payor/Second Insured Rider Only:		
Rider	Duration	Amount	Rider	Duration	Amount
<input type="checkbox"/> Children's Insurance Agreement		\$ _____	<input type="checkbox"/> Payor Benefit (complete employment & medical questions)		
<input type="checkbox"/> X-P Term Rider	_____ yrs.	\$ _____	<input type="checkbox"/> X-P Term Rider	_____ yrs.	\$ _____
<input type="checkbox"/> Disability Income	6 yrs.	\$ _____ per mo.	<input type="checkbox"/> Other _____		
<input type="checkbox"/> GIR		\$ _____			
<input type="checkbox"/> Other _____					

DIVIDEND OPTIONS IF APPLICABLE. Dividends available for participating products only (example: OL)

Dividend Options: Paid-Up Additions Accumulative at Interest Cash Reduced Premium One Year Term

6. List Dependent Children only if CIA Rider coverage is requested.

To be covered children must be *(the Insured's children, legally adopted or step-children. If not living with Proposed insured, please explain)*

Name (Last, First, MI)	Sex	Relationship to Primary Insured	Date of Birth	Height & Weight	Age
	<input type="checkbox"/> M <input type="checkbox"/> F	Child		-	
	<input type="checkbox"/> M <input type="checkbox"/> F	Child		-	
	<input type="checkbox"/> M <input type="checkbox"/> F	Child		-	
	<input type="checkbox"/> M <input type="checkbox"/> F	Child		-	
	<input type="checkbox"/> M <input type="checkbox"/> F	Child		-	
	<input type="checkbox"/> M <input type="checkbox"/> F	Child		-	

7. Information on Existing Insurance

	Primary Insured	Spouse or Other Insureds	Children
A. Do you have any existing insurance or annuity contracts in force or pending? <i>If "Yes" submit form NB-47 (Std-A) 7/00 and complete below.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Will any policy applied for replace or change any existing life insurance or annuities on the life of any proposed covered person? <i>If "Yes" submit all required replacement forms.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

List all existing or pending insurance: <i>Insured Name, Company Name and Address</i>	Type	Amount	ADB Amount	Date Issued

8. Has any person to be Insured:

	Primary Insured	Spouse or Other Insureds
A. Used any form of tobacco or nicotine product in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Ever used any form of tobacco or nicotine product in the past? If "YES" type and date ceased. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

9. - SIMPLIFIED ISSUE QUESTIONS -

**Complete this section ONLY if applying for Simplified E-98 Product (Please refer to height & weight chart and age & amount guidelines)
After completing these questions, refer to Signature - page 4, Agent Report - page 5, and Banking if it applies.**

	Primary	Spouse ONLY	Children Rider ONLY 15 days up to age 18 years
1. Are you actively at work as of this date?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you missed three or more consecutive days of work/school or normal activity due to illness or injury during the last 120 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you within the past 10 years been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), AIDS related conditions, or tested positive for Human Immunodeficiency Virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had a: Heart attack; Heart Bypass; Coronary artery disease; Congestive Heart Failure; Stroke; Cancer (<i>other than Basal Skin Cancer</i>); Chronic Obstructive Lung Disorder or COPD; Emphysema; Liver Disease; Kidney Failure; or Organ Transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been hospitalized in the last 90 days or been recommended to seek: medical advice; treatment; care and/or counseling that has not yet been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If questions 2, 3, 4, 5 are answered YES and/or question 1 is answered NO in section 9, the proposed insured does not qualify for Simplified Issue, and the medical questions as well as any applicable sections on the following pages must be completed.

- NON-SIMPLIFIED ISSUE QUESTIONS -

Complete these questions if insured does not qualify for Simplified Issue. Explain any "yes" answers in Section 11 below:

10. Licensed health care provider includes, but is not limited to, physicians, chiropractors, physical therapists, psychologists, and drug and alcohol, or mental health counselors. Medical facility includes hospital, clinic, mental health facility, and drug or alcohol treatment or consultation facility.			
Has ANY person to be insured:	Primary Insured	Other Insureds and or Payor if covered	Children
A. Within the past 5 years consulted with (<i>including doctor's visits</i>), received treatment from, been advised to receive treatment from a licensed health care provider or medical facility for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Ever had, been told he or she had or been treated for: Cancer; tumors or other malignancy; kidney disease; liver disease; diabetes or urinary tract impairment; lung disease; high blood pressure; stroke; mental disorder; seizure; nervous system disorder; heart or circulatory disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Used on a regular basis or is currently using or ever received treatment or consultation for alcoholism or for the use of heroin, morphine, other narcotics, marijuana, barbituates, amphetamines or hallucinogenic drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Within the past 10 years been diagnosed by or received treatment from a member of the medical profession for Aquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), AIDS related conditions, or tested positive for Human Immunodeficiency Virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Any intention to travel or to reside outside the United States or Canada?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Been convicted, on probation or awaiting trial for a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
G. Within the past five years: had a driver's license suspended or revoked; or been convicted of a moving traffic violation? Driver's License # _____ State _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
H. Planning to or currently engaged in the following activities: aviation; hang gliding; parasailing; racing (any type); rodeo; competitive skiing; scuba; or skydiving? If "Yes", circle activity and submit form NB-AV-Q or form NB-HA-Q .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
I. Ever been declined, postponed, rated or charged an extra premium for health, life or critical illness insurance; been offered a policy different from that applied for; or been refused reinstatement or renewal of life or health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10B. Are you a U.S. citizen? If anyone to be insured is NOT a U.S. citizen provide details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

11. Give complete details in the space below of any "Yes" answers recorded in this application. If more space is needed, attach a signed supplement to the application. (Check Box if supplement is used)

Details to "Yes" Answers		Illness, operation or other cause. Reason for any check-up, doctor's advice treatment and medication (<i>list all medications currently taken</i>)	Diagnosis Dates and Duration	Names, Telephone #'s, Addresses of Doctors and Hospitals
Question #	Name of Proposed Insured			

12. FAMILY HISTORY OF INDIVIDUALS APPLYING FOR INSURANCE:

Have the biological parents, brothers, sisters, either living or deceased, of individuals applying for insurance been treated for or diagnosed with any of the following: diabetes; cancer; high blood pressure; stroke; heart disease; kidney disease or Huntington's Chorea? Yes No
If "Yes", provide details below.

Relative	Name of Insured	Condition	Age at Onset	Age if Living	Age at Death
Mother					
Father					
Siblings					

FINANCIAL QUESTIONS

Complete when applying for the total amount of insurance \$200,000 and over on any insured.

(Please submit copies of financial statements, estate analysis, contractual agreements, etc. if used during the sale.)

What is the purpose of this insurance? _____

(e.g. estate conservation, buy-sell, keyperson)

How was the need for the Face Amount determined? _____

	Primary Insured	Other Insured
Gross annual earned income (salary, commissions, bonuses, etc.)	\$	\$
Gross annual unearned income (dividends, interest, net real estate income, etc.)	\$	\$
Household net worth (combined)	\$	
In the last 5 years, has/have either of the Proposed Life Insured(s), or the business had any major financial problems (bankruptcy, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", give details</i> _____		
Additional Comments:		

- ACKNOWLEDGEMENTS -

To the best of my knowledge and belief, the statements in this application are complete and true. I understand that a "Yes" answer to any question in this application may result in a higher rating or in a declination for this coverage. It is understood that if any statement is a material misrepresentation, coverage may be contested as a result. This application and any supplement shall form the basis for and become part of any policy issued. It is further understood that when the Company gives a Conditional Receipt coverage will start as shown in that form; or when the payroll deduction mode of premium is selected. The insurance shall be in force as of the date of the payroll deduction authorization signed by me, provided the Company receives the first premium from my employer within 90 days of the date hereof and, I am acceptable to the company at the standard premium rate for the plan and amount requested. If the first premium is not received within 90 days, no insurance will become effective.

Otherwise no coverage will start unless: 1) a policy is issued; 2) it is delivered to the applicant; and 3) the full first premium is paid while all persons to be covered are living and their health remains as stated in Sections 9, 10 and 11 if any. If all these take place, coverage will start on the policy date of issue.

The agent has no authority to waive the answers to any questions in or to modify the application.

CONSUMER REPORT AUTHORIZATION

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

**BOSTON MUTUAL LIFE INSURANCE COMPANY
AUTHORIZATION TO OBTAIN INFORMATION FOR INSURANCE UNDERWRITING PURPOSES
(This authorization complies with the HIPAA Privacy Rule)**

I authorize any health plan, insurer, physician, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, services, or payment to the person named above, or on their behalf, as well as the MIB, Inc. (*formally known as the Medical Information Bureau, Inc.*) and other medical information providers, to disclose the entire medical record and any other Protected Health Information concerning such person to the Boston Mutual Life Insurance Company (BML), its employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. The Protected Health Information is being disclosed so that BML may: 1) underwrite/assess an applicant's eligibility for coverage, 2) obtain reinsurance, 3) pay claims and, 4) conduct other legally permissible activities related to the coverage applied for by this individual. This authorization shall remain in force for 24 months following the date of my signature below. A copy of this authorization is as valid as the original. I understand that: I or my authorized representative have the right to revoke this authorization at any time by sending a written request for revocation. Revoking or failing to sign this Authorization may impair BML's ability to process this application; a revocation is not effective to the extent that the Authorization has been relied on for the above listed uses; any information disclosed pursuant to this authorization may be redisclosed and redisclosed information may no longer be covered by federal rules governing privacy or health information. I acknowledge that I have received a copy of BML's Notice of Privacy Practices. I have read this Authorization and understand that I or my authorized representative can receive a copy of it.

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, hereby, designate the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative. This designation shall remain in force for a period of 12 months following my date of death.

"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 fines and confinement in prison"

NOTE: The agent is required to leave with you an original copy of written or printed communications used for presentation of the policy to you.

Application Signed at (State) Signature of Primary Proposed Insured (Parent or Guardian must sign if proposed insured is under age 15)

Date of Application Signature of Other Proposed/Spouse Insured Signature of Owner if other than Primary Proposed Insured, Parent or Guardian

Name and Address of Secondary Addressee

- FOR ANY ADDITIONAL PROPOSED INSURED, SEE ADDENDUM PAGE -

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN					
Bank Draft Plan <input type="checkbox"/> Checking Attach VOIDED check <input type="checkbox"/> Savings Transit/Routing and Account # Required	Bank Name _____ Bank Tel.# _____ Transit/Routing # _____ Account # _____ I authorize the payment of debits drawn on my account payable to Boston Mutual Life Insurance Company, provided there are sufficient funds in the account. I agree that if any such debit be dishonored, you shall be under no liability in the event the dishonored debit results in the forfeiture of insurance. This authority shall remain in effect until revoked by me in writing and until you actually receive such notice of revocation. I request withdrawal of payment on the <input type="checkbox"/> 1st <input type="checkbox"/> 5th <input type="checkbox"/> 10th <input type="checkbox"/> 15th <input type="checkbox"/> 20th or * <input type="checkbox"/> 25th day of each month beginning in the month of _____ * (automatic option if no date is chosen)				
And sign Authorization	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">Date</td> <td>Signature (as it appears on bank records)</td> </tr> <tr> <td></td> <td>Signature of Joint Account Holder (if applicable)</td> </tr> </table>	Date	Signature (as it appears on bank records)		Signature of Joint Account Holder (if applicable)
Date	Signature (as it appears on bank records)				
	Signature of Joint Account Holder (if applicable)				

Comments or Special Requests: _____

AGENT'S REPORT AND CERTIFICATION: (Must be completed in all cases)			
A. Agent relationship to proposed insured(s)? <input type="checkbox"/> Met on solicitation <input type="checkbox"/> Friend <input type="checkbox"/> Relative _____ How long have you known the proposed insured(s)? _____			
B. What are the client's Insurance objectives? <input type="checkbox"/> Mortgage <input type="checkbox"/> Final Expense <input type="checkbox"/> Business Protection <input type="checkbox"/> Other: _____			
C. If Proposed Insured(s) is a dependent, amount of insurance on Parents or Legal Guardian: \$ _____ Are all siblings equally insured? If no, provide details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
D. Did you, with the client's assistance determine the insurance needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
E. Did you see all of those to be insured on the date the application was written and signed?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
F. Do they all reside within the same home?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
G. Did you witness the signing of the application?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
H. Did you read to the client(s) and ask each question on the application exactly as printed?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
I. Was the policy sold using a premium payment plan in which all or part of the future premiums are to be paid with values from loans, dividends or cash surrenders?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
J. To the best of your knowledge and belief, is any life insurance or annuity in force in this or any other company to be replaced in whole or in part by this insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Certification – I certify: (1) that the questions contained in this Application were asked of the Proposed Insured(s) and Owner and the answers were correctly recorded by me; (2) that this Application and any accompanying information are complete and true to the best of my knowledge and belief; and that I have given the Proposed Insured(s)/Owner the Notice of Information Privacy Practices; (3) to the best of my knowledge and belief, the purchase of this insurance coverage will not result in a "stranger originated life Insurance policy" or STOLI transaction; (4) I have reviewed the purchase of this insurance policy as to suitability; (5) that the Proposed Owner/Applicant and Proposed Insured(s) did not exhibit any suspicious behavior that could be related to money laundering activities while completing this application (6) that I have reviewed an unexpired government issued picture ID sufficient to verify the identity of the Proposed Owner(s).			
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Agent's Signature	Print Agent's Name	Agent's Phone Number	Agent's NPN

**Boston Mutual Life Insurance Company does not accept checks with policies for \$500,000.00 and over.
Please Enclose a Signed Illustration for Plans and States where required.**

BOSTON MUTUAL LIFE INSURANCE COMPANY CONDITIONAL RECEIPT FOR LIFE INSURANCE

UNLESS EACH AND EVERY CONDITION SPECIFIED BELOW is fulfilled exactly, no insurance will become effective prior to policy delivery, and the Company's liability will be limited to the refund of the payment for which this receipt is given. No Agent of the Company is authorized to alter or waive any such conditions.

Received from _____ the sum of \$ _____ being payment on account of an application for life insurance to the Boston Mutual Life Insurance Company, which application bears the same date and number of this receipt.

The insurance applied for shall take effect (subject to the Limit of Liability) on the later of the date of the completed application on the last of any medical examinations or tests required by the Company, provided that the following conditions are fulfilled:

1. This payment must be equal to one monthly premium for the policy(s) applied for.
2. On the date the insurance is to be effective the Proposed Insured(s) must be acceptable to the Company at the standard premium rate for the plan and amount requested.

LIMIT OF LIABILITY: Any life insurance, including any accidental death benefits, effective under this Conditional Receipt shall not exceed \$100,000 on any person. This limit includes any such benefits already in force in the Company. Any premium paid in excess of such maximum liabilities shall create no additional liability on the part of the Company. This receipt shall be void in event of dishonor of any check or draft given for said payment and shall automatically become void at the end of sixty days after the date here of. This limit of liability shall be applicable to the insurance applied for under this and any other pending application. If the application is not approved within sixty days, the application file will be closed and you will be so notified. If you do not receive a contract or refund within sixty days please notify the Company. Give the amount paid, date of payment and name of the person to whom paid.

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

Agent Date

APPLICATION SUPPLEMENT

ADDITIONAL CHILDREN FOR CHILDREN INSURANCE AGREEMENT (CIA) RIDER

Name (Last, First, MI)	Sex	Relationship to Primary Insured	Date of Birth	Height & Weight	Age
1.	<input type="checkbox"/> M <input type="checkbox"/> F	Child		-	
2.	<input type="checkbox"/> M <input type="checkbox"/> F	Child		-	
3.	<input type="checkbox"/> M <input type="checkbox"/> F	Child		-	
4.	<input type="checkbox"/> M <input type="checkbox"/> F	Child		-	

ADDITIONAL HEALTH INFORMATION ON PROPOSED INSUREDS/PAYOR AND CHILDREN

Insured's Name:	Medical Condition	Medications	Dates	Dr. Name, Address, Tel. #
1.				
2.				
3.				

ADDITIONAL BENEFICIARY INFORMATION

Primary Beneficiary: Name	Address	Relationship to Primary Insured	% of Share	Age	Date of Birth	Date of Trust
1.						
2.						
Contingent Beneficiary: Name	Address	Relationship to Primary Insured	% of Share	Age	Date of Birth	Date of Trust
1.						
2.						

Proposed Insured Signature _____ Signature of Second Insured or Payor _____ Date _____

Proposed Insured's previous address if moved within 2 years: _____

ILLUSTRATION CERTIFICATION AND ACKNOWLEDGMENT

(Only to be completed for policies with no illustration, for specific states and participating plans of insurance)

- I certify that a life insurance policy illustration(s) was not used during the sale of this life insurance policy.
- I certify that the policy(ies) applied for is other than as illustrated by me.
- I certify that a proposal was shown on a computer screen, but no hard copy(ies) was furnished.

Agent's Signature _____ Date _____

APPLICANT'S ACKNOWLEDGMENT

I acknowledge that a life insurance policy illustration(s) was not given to me at the time my application was written. I further understand that I will receive an illustration(s) at or before the time a policy(ies) is delivered to me.

Applicant's Signature _____ Date _____

Frequently Required Forms - Most forms available at bostonmutual.com

- ABOR Form (state specific)
- Disclosure Form (state of PA ONLY)
- HIV Consent Form (state specific) - (required with applications requiring Blood, Urine or Saliva)
- Replacement forms –
 - NB-47(std-A)7/00 (use when there is any existing insurance in force)
 - State Specific Replacement form
 - NB104 (Revised 7/07)
 - NB47-Adv(7/00) advertising statement- replacements

- APPLICATION ADDENDUM -

Complete if additional insureds are to be covered for **Non-Simplified Individual Insurance only**. Please note **this addendum may only be used if the owner of all additional policies is the same person and is the owner listed under section 3 of this application**. If you wish to list different owners, or want additional riders, or want different dividend options this addendum cannot be used; an individual application will need to be submitted. Each insured under this addendum must answer all questions, provide details to yes answered questions listed in sections 3,4,7,8,10,10B,11,12 and complete the financial section if applicable. **(Refer to the back of this page for all additional insureds to sign and date this addendum)**.

Additional Proposed Insureds will have same owner, plan and mode of payment.

1. Name of Additional Proposed Insured				Relationship to Owner	Date of Birth <small>Month Day Year</small>	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	APL <input type="checkbox"/> Yes <input type="checkbox"/> No
Place of Blrth		Social Security Number - -		Height & Weight _ ft. _ in. _ lbs.		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		
Amount of Insurance \$	Beneficiary Name & Address			Age	Date of Birth <small>Month Day Year</small>	Relationship to Proposed Insured		
Premium Amount \$	WP <input type="checkbox"/> Y <input type="checkbox"/> N	ADB <input type="checkbox"/> Y <input type="checkbox"/> N <small>Amt.</small>	Employer & Address		Occupation		Monthly Income \$	
Actively at Work <input type="checkbox"/> Yes <input type="checkbox"/> No	Proposed Insured Address if different from Owner's:			Telephone Numbers Home: _____ Other: _____				

2. Name of Additional Proposed Insured				Relationship to Owner	Date of Birth <small>Month Day Year</small>	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	APL <input type="checkbox"/> Yes <input type="checkbox"/> No
Place of Blrth		Social Security Number - -		Height & Weight _ ft. _ in. _ lbs.		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		
Amount of Insurance \$	Beneficiary Name & Address			Age	Date of Birth <small>Month Day Year</small>	Relationship to Proposed Insured		
Premium Amount \$	WP <input type="checkbox"/> Y <input type="checkbox"/> N	ADB <input type="checkbox"/> Y <input type="checkbox"/> N <small>Amt.</small>	Employer & Address		Occupation		Monthly Income \$	
Actively at Work <input type="checkbox"/> Yes <input type="checkbox"/> No	Proposed Insured Address if different from Owner's:			Telephone Numbers Home: _____ Other: _____				

3. Name of Additional Proposed Insured				Relationship to Owner	Date of Birth <small>Month Day Year</small>	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	APL <input type="checkbox"/> Yes <input type="checkbox"/> No
Place of Blrth		Social Security Number - -		Height & Weight _ ft. _ in. _ lbs.		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		
Amount of Insurance \$	Beneficiary Name & Address			Age	Date of Birth <small>Month Day Year</small>	Relationship to Proposed Insured		
Premium Amount \$	WP <input type="checkbox"/> Y <input type="checkbox"/> N	ADB <input type="checkbox"/> Y <input type="checkbox"/> N <small>Amt.</small>	Employer & Address		Occupation		Monthly Income \$	
Actively at Work <input type="checkbox"/> Yes <input type="checkbox"/> No	Proposed Insured Address if different from Owner's:			Telephone Numbers Home: _____ Other: _____				

4. Name of Additional Proposed Insured				Relationship to Owner	Date of Birth <small>Month Day Year</small>	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	APL <input type="checkbox"/> Yes <input type="checkbox"/> No
Place of Blrth		Social Security Number - -		Height & Weight _ ft. _ in. _ lbs.		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		
Amount of Insurance \$	Beneficiary Name & Address			Age	Date of Birth <small>Month Day Year</small>	Relationship to Proposed Insured		
Premium Amount \$	WP <input type="checkbox"/> Y <input type="checkbox"/> N	ADB <input type="checkbox"/> Y <input type="checkbox"/> N <small>Amt.</small>	Employer & Address		Occupation		Monthly Income \$	
Actively at Work <input type="checkbox"/> Yes <input type="checkbox"/> No	Proposed Insured Address if different from Owner's:			Telephone Numbers Home: _____ Other: _____				

Comments:								
-----------	--	--	--	--	--	--	--	--

- ACKNOWLEDGEMENTS -

To the best of my knowledge and belief, the statements in this application are complete and true. I understand that a "Yes" answer to any question in this application may result in a higher rating or in a declination for this coverage. It is understood that if any statement is a material misrepresentation, coverage may be contested as a result. This application and any supplement shall form the basis for and become part of any policy issued. It is further understood that when the Company gives a Conditional Receipt coverage will start as shown in that form; or when the payroll deduction mode of premium is selected. The insurance shall be in force as of the date of the payroll deduction authorization signed by me, provided the Company receives the first premium from my employer within 90 days of the date hereof and, I am acceptable to the company at the standard premium rate for the plan and amount requested. If the first premium is not received within 90 days, no insurance will become effective.

Otherwise no coverage will start unless: 1) a policy is issued; 2) it is delivered to the applicant; and 3) the full first premium is paid while all persons to be covered are living and their health remains as stated in Sections 9, 10 and 11 if any. If all these take place, coverage will start on the policy date of issue.

The agent has no authority to waive the answers to any questions in or to modify the application.

CONSUMER REPORT AUTHORIZATION

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

**BOSTON MUTUAL LIFE INSURANCE COMPANY
AUTHORIZATION TO OBTAIN INFORMATION FOR INSURANCE UNDERWRITING PURPOSES
(This authorization complies with the HIPAA Privacy Rule)**

I authorize any health plan, insurer, physician, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, services, or payment to the person named above, or on their behalf, as well as the MIB, Inc. (*formally known as the Medical Information Bureau, Inc.*) and other medical information providers, to disclose the entire medical record and any other Protected Health Information concerning such person to the Boston Mutual Life Insurance Company (BML), its employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. The Protected Health Information is being disclosed so that BML may: 1) underwrite/assess an applicant's eligibility for coverage, 2) obtain reinsurance, 3) pay claims and, 4) conduct other legally permissible activities related to the coverage applied for by this individual. This authorization shall remain in force for 24 months following the date of my signature below. A copy of this authorization is as valid as the original. I understand that: I or my authorized representative have the right to revoke this authorization at any time by sending a written request for revocation. Revoking or failing to sign this Authorization may impair BML's ability to process this application; a revocation is not effective to the extent that the Authorization has been relied on for the above listed uses; any information disclosed pursuant to this authorization may be redisclosed and redisclosed information may no longer be covered by federal rules governing privacy or health information. I acknowledge that I have received a copy of BML's Notice of Privacy Practices. I have read this Authorization and understand that I or my authorized representative can receive a copy of it.

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, hereby, designate the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative. This designation shall remain in force for a period of 12 months following my date of death.

"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 fines and confinement in prison"

NOTE: The agent is required to leave with you an original copy of written or printed communications used for presentation of the policy to you.

1. <input type="text"/>	<input type="text"/>	<input type="text"/>
Application Signed at (State)	Signature of Additional Proposed Insured (Parent or Guardian must sign if proposed insured is under age 15)	Date

<input type="text"/>
Name and Address of Secondary Addressee

2. <input type="text"/>	<input type="text"/>	<input type="text"/>
Application Signed at (State)	Signature of Additional Proposed Insured (Parent or Guardian must sign if proposed insured is under age 15)	Date

<input type="text"/>
Name and Address of Secondary Addressee

3. <input type="text"/>	<input type="text"/>	<input type="text"/>
Application Signed at (State)	Signature of Additional Proposed Insured (Parent or Guardian must sign if proposed insured is under age 15)	Date

<input type="text"/>
Name and Address of Secondary Addressee

4. <input type="text"/>	<input type="text"/>	<input type="text"/>
Application Signed at (State)	Signature of Additional Proposed Insured (Parent or Guardian must sign if proposed insured is under age 15)	Date

<input type="text"/>
Name and Address of Secondary Addressee

SERFF Tracking Number: BSTN-127202820 State: Arkansas
 Filing Company: Boston Mutual Life Insurance Company State Tracking Number: 49009
 Company Tracking Number: IND-11-008
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: General Agency Simplified Underwriting Application
 Project Name/Number: GA SI Underwriting Application/IND-11-008

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments: Please find the Readability Certification attached.		
Attachment: ReadabilityCertification2.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: This is an application filing only.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: This is an application filing only.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter		
Comments: Please find the Cover Letter attached.		
Attachment: Coverletter.pdf		



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
NB1 SF/SD 4/11	65.8

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: April 26, 2011



Peggy Schwartz, FLMI, ALHC, AIRC
Product Filing Manager

April 26, 2011

VIA SERFF

RE: Boston Mutual Life Insurance Company
NAIC # 61476 FEIN #04-1106240
Individual Life Insurance Application Form:
Form #: NB1 SF/SD 4/11

Company Filing No. IND-11-008

We are submitting for approval the above application form. This is a new form and does not replace any existing form.

This is a simplified underwriting application which will be used by licensed independent agents and brokers in the individual life insurance market. It will be used to apply for both whole life and term life coverage under policy forms approved in your state.

The form does not contain any unusual or controversial items from the standpoint of normal company or industry standards. The form is in final print, 10-point type. It meets the minimum readability requirements of this state and a certification is included with this filing. To the best of our knowledge and belief, this submittal complies with the laws and regulations of your state.

DOMICILIARY APPROVAL: This form was filed concurrently in Massachusetts our state of domicile.

Please call me if you have any questions regarding this filing.

Sincerely;

A handwritten signature in black ink that reads "Peggy Schwartz". The signature is written in a cursive, flowing style.

Peggy Schwartz, FLMI, ALHC, AIRC
Product Filing Manager
781 770 0423
Fax: 781 770 0490
Marguerite_schwartz@bostonmutual.com