

State: Arkansas **Filing Company:** Massachusetts Mutual Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: MIB Authorization Update
Project Name/Number: /

Filing at a Glance

Company: Massachusetts Mutual Life Insurance Company
Product Name: MIB Authorization Update
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 10/09/2012
SERFF Tr Num: MASS-128699418
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: MIB AUTHORIZATION

Implementation: On Approval
Date Requested:
Author(s): Steven Miller, Robin Perez, Diana Violette, Jennifer Dube
Reviewer(s): Linda Bird (primary)
Disposition Date: 10/12/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Massachusetts Mutual Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: MIB Authorization Update
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General Information

Project Name: Status of Filing in Domicile: Pending
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 10/12/2012
 State Status Changed: 10/12/2012
 Deemer Date: Created By: Steven Miller
 Submitted By: Steven Miller Corresponding Filing Tracking Number:

Filing Description:

The attached applications are being submitted in order to comply with the Medical Information Bureau requirement for revised authorization language. The A70AR912 is the Application Part 1-Individual Term Life Insurance that will replace the A70AR509 that was approved on 6/30/09. The A3050-9000 0912 is a Life Survey Application, and the A3200-9000 0912 Application (Part 1) will replace the A3200-9000 which was approved on 6/1/90. The A3820-2012 is an Application Part 1B that will replace the A3820-2004 which was approved on 5/27/2004, this form is the only one for use with MML Bay State Life Insurance Company in addition to Massachusetts Mutual Life Insurance Company . The LCM-2012 is an Application (Part 1) For Change To Life Insurance Policy that will replace the LCM-2004 which was approved 5/27/04. The only content that is being changed is the MIB authorization language in each application. Please contact me if you have any questions or concerns. Thank you for your consideration.

Company and Contact

Filing Contact Information

Steve Miller, Compliance Specialist Stevemiller@Massmutual.com
 1295 State Street 860-562-3463 [Phone]
 M-381 860-562-6109 [FAX]
 Springfield, MA 01111-0001

Filing Company Information

Massachusetts Mutual Life Insurance Company	CoCode: 65935	State of Domicile:
1295 State Street	Group Code: 435	Massachusetts
MIP: M381	Group Name:	Company Type:
Springfield, MA 01111	FEIN Number: 04-1590850	State ID Number:
(800) 767-1000 ext. [Phone]		

Filing Fees

Fee Required? Yes
 Fee Amount: \$375.00
 Retaliatory? Yes
 Fee Explanation: 5 x \$75 fee per application.
 Per Company: No

State: Arkansas Filing Company: Massachusetts Mutual Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: MIB Authorization Update
Project Name/Number: /

Company	Amount	Date Processed	Transaction #
Massachusetts Mutual Life Insurance Company	\$375.00	10/09/2012	63592050

SERFF Tracking #:

MASS-128699418

State Tracking #:

Company Tracking #:

MIB AUTHORIZATION

State:

Arkansas

Filing Company:

Massachusetts Mutual Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

MIB Authorization Update

Project Name/Number:

/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/12/2012	10/12/2012

State: Arkansas

Filing Company:

Massachusetts Mutual Life Insurance Company

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: MIB Authorization Update

Project Name/Number: /

Disposition

Disposition Date: 10/12/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Application Part 1- Individual Term Life Insurance		Yes
Form	Application (Part 1)		Yes
Form	Application Part 1B		Yes
Form	Application (Part 1) For Change To Life Insurance Policy		Yes
Form	Survey		Yes

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: MIB Authorization Update
Project Name/Number: /

Filing Company: Massachusetts Mutual Life Insurance Company

Form Schedule

Lead Form Number:							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
1		A70AR912	AEF	Application Part 1- Individual Term Life Insurance	Initial:	58.000	A70AR912.pdf
2		A3200-9000 0912	AEF	Application (Part 1)	Initial:	56.000	A3200-9000 0912.pdf
3		A3820-2012	AEF	Application Part 1B	Initial:	57.000	a3820.pdf
4		LCM-2012	AEF	Application (Part 1) For Change To Life Insurance Policy	Initial:	55.000	lcm-2012.pdf
5		A3050-9000 0912	AEF	Survey	Initial:	54.000	a3050-9000 0912.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

D Primary Purpose of Insurance **COMPLETE THIS SECTION FOR ALL CASES**

- | | | |
|---|---|---|
| 1a. Personal Needs:
<input type="checkbox"/> Income for Dependents
<input type="checkbox"/> Estate Taxes
<input type="checkbox"/> Mortgage Cancellation
<input type="checkbox"/> _____ | 1b. Business Needs:
<input type="checkbox"/> Key Employee
<input type="checkbox"/> Stock Redemption
<input type="checkbox"/> Cross Purchase
<input type="checkbox"/> _____ | 1c. Is this policy being purchased in connection with an employer-sponsored plan?
<input type="checkbox"/> Yes If "Yes", check one of the following:
<input type="checkbox"/> Tax-qualified employer-sponsored plan
<input type="checkbox"/> Non-qualified employer-sponsored plan
<input type="checkbox"/> No |
|---|---|---|

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 2. If the policy applied for will be used in connection with a non-qualified employer-sponsored plan, will the policy be issued on a Unisex basis? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the Proposed Insured and/or the Proposed Owner(s) been offered any economic incentive, "free" life insurance, money, or any other consideration as an incentive to purchase this policy? (If "Yes", explain in Details #8) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does the Proposed Insured and/or the Proposed Owner(s) have a current agreement or commitment to sell, transfer, assign, or release this policy - or any beneficial interest of this policy or its ownership structure - to a life settlement company, viatical company, bank, investor, or secondary market provider? (If "Yes", explain in Details #8) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In connection with this policy, has the Proposed Insured and/or the Proposed Owner(s) entered into an arrangement that entitles a lender or investor to a portion of the death benefit above and beyond the repayment of principal and interest on a loan? (If "Yes", explain in Details #8) _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Complete questions 6-8 if this is a business-related sale

6. Business is a: Corporation LLC/LLP Partnership Sole Proprietorship
- Year Established _____ # of employees _____ Net value of the business \$ _____

7. If a policy is to be owned by a business or business associate, give names of the other officers or partners and the amount of insurance the business now carries on their lives or has currently applied for (if any officers or partners are not insured, explain in Details #8).

Name	Title	Face Amount	% Owned
		\$	
		\$	
		\$	

8. Details (Please reference question number. Attach an additional sheet if necessary.)
- _____
- _____

E Other Insurance/Replacement Information **COMPLETE THIS SECTION FOR ALL CASES**

1. List Life Insurance currently applied for, contemplated, or now in force on the Insured with this or other companies, including any policies which may have been sold, transferred, or assigned. If none, check here:

Policy #	Company	Product	Issue Year	Face Amount
				\$
				\$
				\$

2. Write the total face amount of new insurance applied for that will be placed in all companies (including this Company's policies).
\$ _____

3. Is the insurance now being applied for intended to replace or change any insurance or annuity, in whole or part, issued by this Company or another company? Yes No If "Yes", please provide information below:

Policy #	Company	Product	Issue Year	Face Amount
				\$
				\$
				\$

4. **For Internal Term to Term Replacements Only:**
Do you wish to terminate an existing internal term policy or rider? Yes No (If "Yes", complete Term to Term Replacement Form)

Individually Owned, upon death to his/her estate

- 1. Sex: Male Female
- 2. Full Legal Name

 (First Name) (Middle Initial)

 (Last Name) (Suffix)
- 3a. DOB _____
 (mm/dd/yyyy)
- 3b. Birthplace _____
 (Country/State)
- 4. US Social Security # _____
- 5. Relationship to Proposed Insured _____
- 6. Type of Identification:
 Driver's License
 Passport
 Other (specify) _____
 ID # _____
 Country/State of issue _____
 Expiration Date _____

- 7a. Citizenship:
 US Citizen, Resident US Citizen, Non-Resident
 Alien, Resident Alien, Non-Resident
- 7b. Non-US Citizens provide:
 Country of Citizenship _____
- 8. Email address _____
- 9. Residential Address

 (City) (Country/State) (Zip/Postal Code)
- 10. Mailing Address (if different from Question #9)

 (City) (Country/State) (Zip/Postal Code)

Legal Entity Owned

- 11. Proposed Owner is:
 Trust (**Complete Certification of Trust Agreement F6734**)
 Incorporated Entity, its successors or assigns
 Non-Incorporated Entity
 specify type _____
- 12. Full Name of Legal Entity (If Trust, provide full name of Trust)

- 13. Tax ID #/SSN _____
- 14. Situs of Trust _____
- 15. Citizenship: US Entity Alien Entity
- 16. Email address _____

- 17. Legal Address

 (City) (Country/State) (Zip/Postal Code)
- 18. Mailing Address (if different from Question #17)

 (City) (Country/State) (Zip/Postal Code)

19. Additional Proposed Owner Details

Individually Owned, upon death to his/her estate

- 1. Sex: Male Female
- 2. Full Legal Name

 (First Name) (Middle Initial)

 (Last Name) (Suffix)
- 3a. DOB _____
 (mm/dd/yyyy)
- 3b. Birthplace _____
 (Country/State)
- 4. US Social Security # _____
- 5. Relationship to Proposed Insured _____
- 6. Type of Identification:
 Driver's License
 Passport
 Other (specify) _____
 ID # _____
 Country/State of issue _____
 Expiration Date _____

- 7a. Citizenship:
 US Citizen, Resident US Citizen, Non-Resident
 Alien, Resident Alien, Non-Resident
- 7b. Non-US Citizens provide:
 Country of Citizenship _____
- 8. Email address _____
- 9. Residential Address

 (City) (Country/State) (Zip/Postal Code)
- 10. Mailing Address (if different from Question #9)

 (City) (Country/State) (Zip/Postal Code)

Legal Entity Owned

- 11. Proposed Owner is:
 Trust (Complete Certification of Trust Agreement F6734)
 Incorporated Entity, its successors or assigns
 Non-Incorporated Entity
 specify type _____
- 12. Full Name of Legal Entity (If Trust, provide full name of Trust)

- 13. Tax ID #/SSN _____
- 14. Situs of Trust _____
- 15. Citizenship: US Entity Alien Entity
- 16. Email address _____

- 17. Legal Address

 (City) (Country/State) (Zip/Postal Code)
- 18. Mailing Address (if different from Question #17)

 (City) (Country/State) (Zip/Postal Code)

19. Additional Proposed Owner Details

Individually Owned, upon death to his/her estate

- 1. Sex: Male Female
- 2. Full Legal Name

 (First Name) (Middle Initial)

 (Last Name) (Suffix)
- 3a. DOB _____
 (mm/dd/yyyy)
- 3b. Birthplace _____
 (Country/State)
- 4. US Social Security # _____
- 5. Relationship to Proposed Insured _____
- 6. Type of Identification:
 Driver's License
 Passport
 Other (specify) _____
 ID # _____
 Country/State of issue _____
 Expiration Date _____

- 7a. Citizenship:
 US Citizen, Resident US Citizen, Non-Resident
 Alien, Resident Alien, Non-Resident
- 7b. Non-US Citizens provide:
 Country of Citizenship _____
- 8. Email address _____
- 9. Residential Address

 (City) (Country/State) (Zip/Postal Code)
- 10. Mailing Address (if different from Question #9)

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 specify type _____
- 12. Full Name of Legal Entity (If Trust, provide full name of Trust)

- 13. Tax ID #/SSN _____
- 14. Situs of Trust _____
- 15. Citizenship: US Entity Alien Entity
- 16. Email address _____

- 17. Legal Address

 (City) (Country/State) (Zip/Postal Code)
- 18. Mailing Address (if different from Question #17)

 (City) (Country/State) (Zip/Postal Code)

19. Additional Proposed Owner Details

Individually Owned, upon death to his/her estate

- 1. Sex: Male Female
- 2. Full Legal Name

 (First Name) (Middle Initial)

 (Last Name) (Suffix)
- 3a. DOB _____
 (mm/dd/yyyy)
- 3b. Birthplace _____
 (Country/State)
- 4. US Social Security # _____
- 5. Relationship to Proposed Insured _____
- 6. Type of Identification:
 Driver's License
 Passport
 Other (specify) _____
 ID # _____
 Country/State of issue _____
 Expiration Date _____

- 7a. Citizenship:
 US Citizen, Resident US Citizen, Non-Resident
 Alien, Resident Alien, Non-Resident
- 7b. Non-US Citizens provide:
 Country of Citizenship _____
- 8. Email address _____
- 9. Residential Address

 (City) (Country/State) (Zip/Postal Code)
- 10. Mailing Address (if different from Question #9)

 (City) (Country/State) (Zip/Postal Code)

Legal Entity Owned

- 11. Proposed Owner is:
 Trust (Complete Certification of Trust Agreement F6734)
 Incorporated Entity, its successors or assigns
 Non-Incorporated Entity
 specify type _____
- 12. Full Name of Legal Entity (If Trust, provide full name of Trust)

- 13. Tax ID #/SSN _____
- 14. Situs of Trust _____
- 15. Citizenship: US Entity Alien Entity
- 16. Email address _____

- 17. Legal Address

 (City) (Country/State) (Zip/Postal Code)
- 18. Mailing Address (if different from Question #17)

 (City) (Country/State) (Zip/Postal Code)

19. Additional Proposed Owner Details

Individually Owned, upon death to his/her estate

- 1. Sex: Male Female
- 2. Full Legal Name

 (First Name) (Middle Initial)

 (Last Name) (Suffix)
- 3a. DOB _____
 (mm/dd/yyyy)
- 3b. Birthplace _____
 (Country/State)
- 4. US Social Security # _____
- 5. Relationship to Proposed Insured _____
- 6. Type of Identification:
 Driver's License
 Passport
 Other (specify) _____
 ID # _____
 Country/State of issue _____
 Expiration Date _____

- 7a. Citizenship:
 US Citizen, Resident US Citizen, Non-Resident
 Alien, Resident Alien, Non-Resident
- 7b. Non-US Citizens provide:
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- 8. Email address _____
- 9. Residential Address

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- 10. Mailing Address (if different from Question #9)

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 Non-Incorporated Entity
 specify type _____
- 12. Full Name of Legal Entity (If Trust, provide full name of Trust)

- 13. Tax ID #/SSN _____
- 14. Situs of Trust _____
- 15. Citizenship: US Entity Alien Entity
- 16. Email address _____

- 17. Legal Address

 (City) (Country/State) (Zip/Postal Code)
- 18. Mailing Address (if different from Question #17)

 (City) (Country/State) (Zip/Postal Code)

19. Additional Proposed Owner Details

G Beneficiary Information**COMPLETE THIS SECTION FOR ALL CASES**

Beneficiary - Unless otherwise requested, surviving beneficiaries in any class shall take equally. If any beneficiary dies before the Proposed Insured, payment shall be made to the surviving beneficiaries in that class. If no beneficiary is entitled to the payment at time of claim, the proceeds shall be paid to the Proposed Owner, if living, or to the Proposed Owner's estate.

1a. Beneficiary Type _____ %

Name (If Trust, provide full name of Trust) _____

Relationship to Insured _____ DOB/Date of Trust _____ Primary Contingent

1b. Beneficiary Type _____ %

Name (If Trust, provide full name of Trust) _____

Relationship to Insured _____ DOB/Date of Trust _____ Primary Contingent

1c. Beneficiary Type _____ %

Name (If Trust, provide full name of Trust) _____

Relationship to Insured _____ DOB/Date of Trust _____ Primary Contingent

1d. Beneficiary Type _____ %

Name (If Trust, provide full name of Trust) _____

Relationship to Insured _____ DOB/Date of Trust _____ Primary Contingent

2. UTMA/UGMA Custodian - During the minority of the named child(ren), _____ shall be said Custodian
(name of adult to act as Custodian)
for said child(ren) under the _____ Uniform Transfers/Gifts to Minors Act.
(state)

3. Additional Beneficiary Details (Please attach additional pages as needed)

H Personal History Information**COMPLETE THIS SECTION FOR ALL CASES**

1. Does the Proposed Insured anticipate any foreign travel within the next 2 years? _____ Yes No

2. Within the last 3 years has the Proposed Insured been, or within the next 2 years does s/he expect to become, a pilot, student pilot, or crew member of any type of aircraft? (If "Yes", Aviation Supplement to be completed) _____ Yes No

3. Within the last 3 years has the Proposed Insured taken part in, or within the next 2 years does s/he expect to take part in, underwater diving, hang gliding, para sailing, para kiting, parachuting, skydiving, mountain climbing, bungee jumping, helicopter skiing, or organized racing by automobile, motorcycle, motorboat, snowmobile, or any other form of hazardous activity or extreme sports? (If "Yes", Avocation Supplement to be completed) _____ Yes No

4. Within the last 5 years, has the Proposed Insured been in a motor vehicle accident, been convicted of a moving violation, or received a driver's license restriction or revocation? _____ Yes No

5. Within the last 10 years, has the Proposed Insured been convicted of operating a motor vehicle while under the influence of alcohol or other drugs? _____ Yes No

6. Has the Proposed Insured ever been convicted of a felony, or is s/he currently on parole or probation? _____ Yes No

7a. Annual Earned Income \$ _____ 7b. Unearned Income \$ _____ 7c. Net Worth \$ _____

8. Occupation _____ Duties _____

Employer Name & Address _____

9a. If Proposed Insured is not employed: Household Income \$ _____ 9b. Household Net Worth \$ _____

Life Insurance Coverage - This is part 1 of an application for life insurance. The application includes any part 2 that may be required and any amendments, statements, and supplements to either part. Insurance coverage under the policy takes effect when the policy is delivered and accepted, and the initial premium is paid, provided that on the delivery date (1) the Proposed Insured is alive, (2) all answers on the application, including any amendments to the application, are still true and complete, and there have been no changes in the health or insurability of the Proposed Insured from the date the application was submitted to the company unless Insurability Protection is provided under a Temporary Life Insurance Receipt (TLIR), and (3) any required statement of insurability is completed. Failure to satisfy all of these requirements will result in no insurance coverage taking effect. If a future date is selected at time of application, coverage does not begin prior to that date.

Charges may accrue before insurance takes effect - If a life insurance policy is issued, insurance coverage will begin as defined above. Policy charges will begin on the Policy Date, which is defined in the policy. The Policy Date may occur before insurance under the policy takes effect. If so, you will be charged premiums during a period in which no insurance was in force. To reduce the likelihood of paying such premiums, the Proposed Policy Owner may purchase a TLIR, if eligible, or ask the Company to issue the policy with a future Policy Date. Requesting a specific Policy Date may cause the insured's age for insurance purposes to change and the cost of insurance rates to increase. If you have questions about policy charges or policy dating, ask your MassMutual Representative.

Changes and Corrections - Any material change or correction of the application will be shown on an amendment of application attached to the policy. Acceptance of any policy issued shall be acceptance of any change or correction of the application made by the Company. However, any correction or change in the amount, classification, plan of insurance, or riders applied for in this application must be agreed to in writing.

Authority of Producers - No producer can change the terms of this application or any policy issued by the insurer, waive any of the insurer's rights or requirements, or extend the time for any payment.

Acknowledgement of Receipt of Company Notices and Disclosures - In connection with this application, the Company's notices about the Medical Information Bureau (MIB), the Fair Credit Reporting Act, the Company's privacy practices, and Premium Payment Information have been provided to, and received by, the undersigned.

Authorization to Obtain and Disclose Information for the Proposed Insured and/or Proposed Owner - I authorize the Company to review this application and the information contained therein and to collect and review such other information, as it deems necessary, including such medical and non-medical information as the Company may request. I hereby authorize certain parties that have records or knowledge of me and/or my health, to make such information available to the Company, its reinsurers, its affiliated insurance companies, its agents, employees, and representatives. These parties shall include any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, the MIB, pharmacy data search companies, Department of Motor Vehicles, credit agency, current or former employer, insurance company, and other organizations having information relevant to the issuance or administration of this policy. I further authorize the Company to obtain and conduct a personal history information interview and/or a written inspection in connection with this application, and authorize the Company to obtain an investigative report regarding information about my character, general reputation, personal characteristics, and mode of living. I understand that any and all such information obtained by the Company through such interviews, inspections, or reports may be made available to the Company's agents, employees, and representatives for determining eligibility for insurance, reinsurance, reinstatement requests, or changes in benefits. I also authorize MassMutual, or its reinsurers, to disclose information about me to the MIB in the form of a brief coded report for participation in MIB's fraud prevention and detection programs. This authorization shall be valid for 24 months from the date of my signature on this application. All documents and information submitted to, or acquired by, the Company become property of the Company. A photocopy or facsimile of this authorization may be relied upon as if it were an original.

Taxpayer Identification - By my signature below, I, the Proposed Owner of this Policy, certify, under penalties of perjury, that (i) the number referred to in A4, F4, or F13 is my correct Taxpayer Identification Number; (ii) I am not subject to backup withholding either because (a) I am exempt from backup withholding, (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) because the IRS has notified me that I am no longer subject to backup withholding; and (iii) I am a U.S. person (including U.S. resident alien). If (ii) is incorrect, please strike out and initial. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OF 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.

I have read the application and all statements and answers as they pertain to me, and affirm that these statements and answers are true, complete and correctly recorded to the best of my knowledge and belief. The statements and answers in the application are the basis for any policy issued by the company, and no information about me will be considered to have been given to the company unless it is stated in the application. I hereby adopt all statements made in the application and agree to be bound by them.

Signed on _____ Date _____ City and State where Proposed Owner signed _____

Signature of Proposed Insured _____ **Signature of Soliciting Producer** _____

X _____ **X** _____ Agency # _____
Proposed Insured Soliciting Producer

Signature of Proposed Owner - If Other than Proposed Insured _____ **Signature of Proposed Joint Owner - If Applicable** _____

X _____ **X** _____
Proposed Owner Include Title (if applicable) Proposed Owner Include Title (if applicable)

Producer's Statement

Must be signed by the Soliciting Producer for all cases.
Attach a cover memo if further details are required.

Section A - Case Information: If you answer "Yes" to any of the following questions, please provide details when appropriate or complete supplemental forms specified.

1. Risk classification presented to client: _____
2. Do you want an offer if the case is approved other than as applied for?..... Yes No
3. Is this part of a multi-policy case (i.e. family members, business partners, etc.)?..... Yes No
If "Yes", provide associated Policy Number(s): _____
4. Is there a Disability or Long Term Care Application being submitted concurrently with this Application?.. Yes No
If "Yes", provide associated Policy Number(s): _____
5. Is the policy being applied for a Replacement?..... Yes No
6. Will dividends from an existing MassMutual policy be used to pay all or part of the initial premium on this policy?..... Yes No
If "Yes", complete Service Request Form F5341.
7. Is the Life Insurance being applied for in conjunction with the purchase of a Single Premium Immediate Annuity?..... Yes No
If "Yes", provide associated Policy Number(s): _____
8. Are you aware of whether the Proposed Owner or Proposed Insured has arranged, or discussed arranging, any financing for the purchase of this policy?..... Yes No
If "Yes", complete Premium Financing Supplement F7002.
9. Do you have any knowledge or reason to believe the Proposed Insured has any present or future intention to sell or assign this policy, or has ever sold or assigned any policy, to a life settlement, viatical or other secondary market provider?..... Yes No

10. **(For Variable Products only)** Did you deliver a current copy of the Prospectus and any applicable supplements?..... Yes No
Prospectus Effective Date (from front cover of prospectus):..... _____
mm/dd/yyyy

Section B - Producer Compensation Information: Please complete the first line on all applications, and provide any additional Compensation arrangements when needed.

	Producer ID #	Printed Name	Agency #/ Distributor ID	Entity Name/Entity #	% 1st Year Commission	% Renewal Commission
1	Soliciting					
2						
3						
4						
5						
6						
7						
8						
(For SWL Products only) Agency Split - If the sale of this policy will be credited to more than one agency/entity, list % for each			Agency #	% of Split	Total	% Total

Section C - Marketing: Which Sales and Marketing programs were used to support this sale? (select all that apply)

- Business Owner Existing Customer SpecialCare - Families with Special Needs
 Women's Markets Multicultural Initiative Families & Individual Markets
 Other: _____

I certify to the best of my knowledge, information and belief that: (a) The statements made in this Producer Statement are true and accurate. (b) Each question in the Application was asked of the Proposed Insured(s) and Proposed Owner(s) and accurately recorded. (c) I am unaware of any suspicious or unusual activities, including but not limited to Anti-Money Laundering (AML) "red flags" as described in my AML training or other materials, arising out of or in connection with, the sale of this policy. I have reported suspicious activity, if any, to the appropriate individuals in accordance with MassMutual's AML program. (d) The policy applied for is consistent with the financial needs of the Proposed Insured(s) and/or Owner(s). (e) I am unaware of any information that would adversely affect any of the Proposed Insured's eligibility, acceptability or insurability.

X

Signature of Soliciting Producer

Soliciting Producer ID #

Section D - Agency Contact: If the underwriter/case manager needs information or has questions about this case, please contact:

Name: _____ Phone: _____ Email: _____
Name: _____ Phone: _____ Email: _____

APPLICATION (PART 1)

APPLICATION NO.

TO:

Massachusetts Mutual Life Ins. Co.

MML Bay State Life Ins. Co.

Springfield, Massachusetts 01111-0001

For: New Annuity New Life Insurance UL/VL Increase Conversion of Term _____

Client Data

1. The Application consists of this Part 1, Part 2, and Employer Sponsor Supplement To Application No. _____

2. Plan Account Name: _____ Plan Account No. _____

3. Name and Address of Proposed Insured or Annuitant (hereinafter referred to as the Insured or Annuitant):

first name _____ middle name _____

last name _____ suffix _____

street & no. _____ city _____ state _____ zip _____

mo. _____ day _____ yr. _____

4. Social Security No. _____ - _____ - _____

5. Male Female

8. Date of Birth _____

9. Age for Issue of Policy(ies) (optional): _____

6. Birthplace: _____

10. Citizenship, if not USA: _____

Type of Visa
 Perm.
 Temp.

7. Date of Employment (current employer): _____

Annuity Data

11. Plan (select one):

- Flexible Purchase Payment Contract (FPPVA)
- Single Purchase Payment Contract (SPPVA) (\$25,000 minimum)
- Retirement Annuity (RA)
- Modified Premium Retirement Annuity (RIA) with Reducing Term Life Insurance Rider
- Single Premium Retirement Annuity (SPRA)
- Retirement Annuity with Flexible Premiums (RAFP)

12. Rider(s):

- Waiver of Premium
- Annuitant Exchange (VA Only)
- ADB (RIA only) \$ _____
- _____

13. Contract/Policy Date: _____

14. Maturity (select one):

- Contract Anniversary nearest age 65 70 _____
- Date _____ (VA only)

15. Purchase Payments (Variable Annuity):

- (a) First Payment \$ _____
- (b) Amount to be billed: \$ _____
- (c) Rollover Amount (if any, included in First Payment): \$ _____

16. Premium / Monthly Income (Fixed Annuity - Select one):

- Normal Premium on frequency elected: \$ _____
- Single Premium: \$ _____
- \$ _____ Monthly Income

(Payments/Premiums specified in 15 or 16 include all riders unless otherwise indicated in 32.)

Life Insurance Data

17. Plan (select one):

- Whole Life
- Limited Pay WL 65 95
- Yearly Term Life (YTL)
- UL or VL increase for Policy # _____
- Variable Life Plus
- Universal Life

18. Riders:

- Waiver of Premium
- Waiver of Premium with Right To Change To Retirement income while Disabled Benefit
- Accidental Death Benefit (ADB) \$ _____
- Add'l Life Ins. Purchase (ALIR) \$ _____
- _____ \$ _____

19. Amount of Insurance (a or b):

- (a) Face Amount \$ _____
- (b) Face Amount purchased by a premium of \$ _____ at premium frequency applied for.
- This premium includes all riders.

20. Variable Life and Universal Life Plans:

- (a) First Premium: \$ _____
- (b) Planned Premium (at frequency): \$ _____
- (c) Death Benefit Option (if applicable): 1 2

21. Automatic Premium Loan: Yes No (not available on Term or Variable Life)

22. Loan Interest Rate (where elective):

- Adjustable 8% 6% (VL only) _____ %

23. Policy Date: _____

General Data

<p>24. Variable Annuity Purchase Payment Allocation:</p> <p>(a) Equity Division _____ %</p> <p>(b) Money Market Division _____ %</p> <p>(c) Managed Bond Division _____ %</p> <p>(d) Blend Division _____ %</p> <p>(e) Guaranteed Principal Account _____ %</p> <p>(f) _____ %</p> <p style="text-align: right;">100%</p>	<p>25. Variable Life Plan Net Premium Allocation:</p> <p>(a) Equity Division _____ %</p> <p>(b) Money Market Division _____ %</p> <p>(c) Managed Bond Division _____ %</p> <p>(d) Blend Division _____ %</p> <p>(e) Guaranteed Principal Account _____ %</p> <p>(f) _____ %</p> <p style="text-align: right;">100%</p>
--	---

26. Payee (annuity only): Income payments are to be paid to the Annuitant unless otherwise requested here.

27. Dividend Option (if applicable):

<p>(a) Annuity</p> <p><input type="checkbox"/> Reduce Premium <input type="checkbox"/> Cash</p> <p><input type="checkbox"/> Paid-up Additions <input type="checkbox"/> _____</p>	<p>(b) Life Insurance</p> <p><input type="checkbox"/> Reduce Premium <input type="checkbox"/> Cash <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Paid-up Additions <input type="checkbox"/> Accumulate at Interest</p>
--	--

28. ALIR Dividend Option Paid-up Additions Same as Basic Policy

29. (a) Will the insurance or annuity now being applied for replace or change, or is it intended to replace or change, any insurance or annuity, in whole or in part, issued by this or any other company? Yes No **If "Yes", give company name, amount of life insurance, policy number and plan in 32.**

(b) Are all or part of the surrender proceeds of any policy listed in 32 being used to purchase the applied for policy? Yes No

30. Premium Payments:

<p>Annuity: (a) Premium Frequency:</p> <p><input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly</p> <p><input type="checkbox"/> Quarterly for first Policy Year, annually thereafter</p> <p><input type="checkbox"/> One month with balance of <input type="radio"/> Annual <input type="radio"/> Semiannual <input type="radio"/> Quarterly</p> <p>Life Ins.: (a) Premium Frequency:</p> <p><input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly</p> <p><input type="checkbox"/> Quarterly for first Policy Year, annually thereafter</p> <p><input type="checkbox"/> One month with balance of <input type="radio"/> Annual <input type="radio"/> Semiannual <input type="radio"/> Quarterly</p>	<p>(b) Billing Type:</p> <p><input type="checkbox"/> Invoice Billing</p> <p><input type="checkbox"/> Triple M (mo. only)</p> <p><input type="checkbox"/> Suppress Billing (VA only)</p> <p>(b) Billing Type:</p> <p><input type="checkbox"/> Invoice Billing</p> <p><input type="checkbox"/> Triple M (mo. only)</p> <p><input type="checkbox"/> _____</p>
---	--

31. Has the first premium on the annuity or insurance applied for been paid?

Annuity: Yes No

Life Ins.: Yes No

32. Remarks:

Underwriting Data For Life Insurance And For Annuity With Waiver

Personal Data Regarding the Insured

33. (a) What is his/her Occupation(s) and Exact Duties:

Occupation(s)	Exact Duties
---------------	--------------

34. Has he/she smoked cigarettes in the last 12 months? Yes No

35. Is he/she now actively working a minimum of 1,000 hours annually? Yes No

Optional SI And Regular Issue Underwriting

36. Has he/she ever been treated for, or been diagnosed by a member of the medical profession as having, a deficiency of the immune system? Yes No

37. Has he/she ever consulted or been treated by a physician for cancer or disease of the heart? Yes No

38. Has he/she applied for life insurance and been declined or postponed in the last 5 years? Yes No

Regular Issue Underwriting

39. Within the last 3 years, has he/she been, or does he/she now expect to become, a pilot, student pilot or crew member of any type of aircraft? **If "Yes," complete Aviation Supplement A3310** Yes No

40. Within the last 3 years, has he/she taken part in, or does he/she now expect to take part in, underwater diving, hang gliding, para sailing, para kiting, parachuting, skydiving, mountain climbing, or organized racing by automobile, motorcycle, motorboat or snowmobile? If "Yes," complete Avocation Supplement A3320 Yes No

OMIT 41 - 47 IF PART 2 BEING SUBMITTED

41. Has he/she ever been advised of, treated for, or had any known indication of: (If "Yes", explain in 43 below.)

	Yes	No		Yes	No
(a) Heart or blood vessel disease (e.g. hardening of the arteries, poor circulation, stroke)?	<input type="checkbox"/>	<input type="checkbox"/>	(g) Cancer or tumor?	<input type="checkbox"/>	<input type="checkbox"/>
(b) High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	(h) Liver, digestive or bowel disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	(i) Impairment of speech, hearing or sight?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Kidney or other urinary disorder?	<input type="checkbox"/>	<input type="checkbox"/>	(j) Blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Lung disorder?	<input type="checkbox"/>	<input type="checkbox"/>	(k) Arthritis, bone, joint or other muscular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Nervous system or psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>	(l) Any physical or health impairment not previously noted?	<input type="checkbox"/>	<input type="checkbox"/>

42. Is he/she now taking any medicine or under any other treatment not already noted? (If "Yes", explain in 43 below.) Yes No

43. Complete 43 For Each "Yes" Answer in 41 & 42 Above

A. Ques. No.	Diagnosis	Medication/Treatment	Still Under Treatment	# of Attacks/ Occurrences	Dates (mo/yr)	
			<input type="checkbox"/> Yes <input type="checkbox"/> No		Onset	Recovery
Physician/Medical Facility Name		Address			ZIP	
B. Ques. No.	Diagnosis	Medication/Treatment	Still Under Treatment	# of Attacks/ Occurrences	Dates (mo/yr)	
			<input type="checkbox"/> Yes <input type="checkbox"/> No		Onset	Recovery
Physician/Medical Facility Name		Address			ZIP	

44. Has he/she received any treatment in relation to use of alcohol, drugs, or other chemical substance? (If "Yes", explain in 46 below.) Yes No

45. (a) Height in shoes _____ ft. _____ in. (b) Weight (clothed) _____ lbs. (c) Loss in weight in the past year? Yes No If "Yes", Amount _____ lbs. Reason _____

46. Remarks (give question no. & details):

47. Personal Physician Information

a. Name / Address given in: 43A 43B
 Have no personal physician
 Other - give Personal Physician Name / Address here:

Physician Name _____
Address _____
City _____ State _____ ZIP _____

b. Reason you last consulted this physician.
 As indicated in: 43A 43B
 Routine or General Exam - all findings normal
 Other - give details here: _____

Date Last Seen _____
Diagnosis or Reason Last Seen _____
Medication/Treatment _____

Agreement and Signature

To the best of my knowledge and belief, all answers and statements are full, complete and true and were correctly recorded before I signed my name below.

Authorization to Obtain and Disclose Information - I have received the Notice regarding the MIB and the Fair Credit Reporting Act. I understand that an investigative consumer report may be made regarding my character, general reputation, personal characteristics and mode of living, and authorize that report to be made. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, the MIB, or other organization that has any records or knowledge of me and my health, to make such information available to Massachusetts Mutual Life Insurance Company, MML Bay State Life Insurance Company or its reinsurers. I also authorize MassMutual, or its reinsurers, to disclose information about me to the MIB in the form of a brief coded report for participation in MIB's fraud prevention and detection programs. A copy of this authorization shall be as valid as the original. (This authorization is only valid where permitted by law.)

Proposed Insured

Signature of Soliciting Agent

Signed at: _____
City State Date



Application Part 1B

To: _____ Massachusetts Mutual Life Insurance Company
1295 State Street
Springfield, Massachusetts 01111-0001

_____ MML Bay State Life Insurance Company
100 Bright Meadow Boulevard
Enfield, Connecticut 06082

The words "we," and "our" refer to the life insurance company specified above.
Underwriting Method: _____ Guaranteed Issue (Complete Section 1 Only)
_____ Simplified Issue (Complete Sections 1 & 2) _____ Full Underwriting (Complete Sections 1, 3 & 4 Only)

SECTION 1

► Proposed Owner Information

1. **Policy/Certificate Owner Name** (Complete only if question 1d. is checked on application Part 1A): _____
 - a. **Name of Trustee(s)** (if applicable)*: _____
 - b. **Date of Trust** (if applicable): _____ *If trust, signed Certification Of Trust Agreement (or a trust copy) is required.
2. **Policy/Certificate Owner Address (No. & Street):** _____
City, State, Zip: _____
 - a. **Policy/Certificate Owner's Taxpayer ID Number/Social Security Number:** _____
 - b. **Policy/Certificate Owner's Telephone Number:** Home: _____ Work: _____
3. **Program Sponsor Name:** _____

► Proposed Insured Information

4. **Proposed Insured's Name** (Last, First, MI): _____
5. **Date of Birth:** _____ mo. _____ day _____ year
6. **Birthplace:** _____
7. **Sex:** _____ Male _____ Female
8. **Social Security Number** _____
9. **Proposed Insured's Telephone Number:** Home: _____ Work: _____
10. **U.S. Citizen:** _____ Yes _____ No **If not U.S., what country?** _____
Type of Visa: _____ Perm _____ Temp **Visa ID #:** _____
Passport ID # for non U.S., non Visa holders: _____
11. **Proposed Insured's Home Address (No. & Street):** _____
City, State, Zip _____
12. **Proposed Insured's Business Address (No. & Street):** _____
City, State, Zip _____
13. **Proposed Insured's Regular Place of Work Address (No. & Street):** _____
(if different than business address)
City, State, Zip _____
14. **Proposed Effective Date:** _____ mo. _____ day _____ year
15. **Rider Option** (if applicable): _____ Yes _____ No
16. **First premium paid with application \$** _____ **Planned premium for year one \$** _____

Beneficiary Information

Complete only if question 28b is checked on Application Part 1A.

17. For all beneficiaries, print full name(s) and relationship(s) to the Proposed Insured.

Death benefit proceeds will be paid in one sum unless otherwise requested.

Beneficiary	Relationship	Address
a. Primary _____	_____	_____
b. Secondary (Optional) _____	_____	_____
c. Tertiary (Optional) _____	_____	_____

If two or more persons are the beneficiaries in any class, payment shall be made equally to them or equally to the surviving beneficiaries in that class unless otherwise requested. If percentages or fractions are indicated and any beneficiary dies before the Insured, any share due that beneficiary will be paid proportionately to the surviving beneficiaries in that class. If payment is made in one sum and there is no beneficiary entitled to payment when the Insured dies and the Insured is the Owner at that time, payment shall be made to the estate of the Insured, but if the Insured is not the Owner, payment shall be made to the Owner.

Personal Information Regarding the Proposed Insured

18. Has the Proposed Insured been actively at work on a full-time basis beginning with and during the 90 days prior to the date of signing this application Part 1B? "Actively at work" means working full time at a rate of at least 30 hours per week with no hospitalization and no absence due to illness or accident of more than 5 consecutive business days or a cumulative total of 7 days.

___ Yes ___ No **If "No," give detailed explanation in Remarks section.**

a. Is the Proposed Insured actively at work for another employer? **If "Yes," give detailed explanation (including name and address of employer) in Remarks section.**

19. Is the Proposed Insured currently receiving or applying to receive disability compensation? ___ Yes ___ No

If "Yes," explain in Remarks section.

20. Has the Proposed Insured smoked cigarettes in the last 12 months? ___ Yes ___ No **If "Yes," specify in Remarks section.**

21. Has the Proposed Insured used any tobacco or nicotine products within the past 12 months? ___ Yes ___ No **If "Yes," please give the type, frequency and last date used _____.**

22. Proposed Insured's annual earned income: \$ _____ Proposed Insured's financial net worth: \$ _____

23. Proposed Insured's current driver's license no. _____ State _____

24. Amount of insurance currently applied for, or now in force, on the Proposed Insured in this or other companies.

If none, check here. ___

Company Name	Face Amount	Year Issued	Application Pending ___ Yes ___ No

25. List all occupations of Proposed Insured and the exact duties of each.

Occupation(s)	Exact Duties

26. (Complete only if employer will be owner and beneficiary) Please check one:

- a. Yes. I consent to my employer purchasing a life insurance policy on my life. I agree and understand that:
- The employer will pay all the premiums, have all the rights of ownership, and be the sole beneficiary of the policy. I agree that my administrators, estate, heirs and assigns have no rights to any policy proceeds; and
 - The employer or their successors will continue to be the owner and beneficiary of the policy(ies) after the end of my employment with the employer or its successors.
- b. No. I do not consent to my employer purchasing a life insurance policy on my life.

Replacement Information (Required)

27. Is the insurance now being applied for intended to replace or change any insurance or annuity, in whole or part, issued by this or another company? Yes No **If "Yes" complete information below:**

Company	Policy Number	Product	Amount	1035 Exchange
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

28. If 1035 exchange: approximate value of exchange \$_____ (In Remarks Section, indicate how 1035 money will be applied on the new policy.)

SECTION 2

Simplified Issue

- | | Yes | No |
|---|-----|-----|
| 29. Has the Proposed Insured ever been treated for, or been diagnosed by a member of the medical profession as having, a deficiency of the immune system, such as Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC)? .. | ___ | ___ |
| 30. Has the Proposed Insured ever consulted, been treated by or been diagnosed by a member of the medical profession for any of the following: cancer, diabetes, tumor, stroke, high blood pressure, psychiatric or mental disorder, alcohol or drug abuse or a disorder or disease of the heart or cardiovascular system, lung, kidney, liver, brain or nervous system? .. | ___ | ___ |
| 31. Has the Proposed Insured applied for life insurance and been declined, rated, restricted or postponed in the last 10 years? .. | ___ | ___ |
| 32. Does the Proposed Insured anticipate any foreign travel and/or have a foreign residence? (If "Yes" complete Foreign Travel Supplement)..... | ___ | ___ |

If "Yes" answers given in 29, 30, or 31, give details in Remarks section.

SECTION 3

Full Underwriting

- | | Yes | No |
|--|-----|-----|
| 33. Does the Proposed Insured anticipate any foreign travel and/or have a foreign residence? (If "Yes" complete Foreign Travel Supplement)..... | ___ | ___ |
| 34. Within the last 3 years has the Proposed Insured been, or does s/he expect to become, a pilot, student pilot, or crew member of any type of aircraft? (If "Yes" complete Aviation Supplement) .. | ___ | ___ |
| 35. Within the last 3 years has the Proposed Insured taken part in, or does s/he expect to take part in, underwater diving, hang gliding, para sailing, para kiting, parachuting, skydiving, mountain climbing, bungee jumping, helicopter skiing, or organized racing by automobile, motorcycle, motorboat, or snowmobile, or any other form of hazardous activity or extreme sports? (If "Yes" complete Avocation Supplement)..... | ___ | ___ |
| 36. Within the last 5 years has the Proposed Insured been in a motor vehicle accident, been convicted of a moving violation, or received a driver's license restriction or revocation? .. | ___ | ___ |
| 37. Within the last 10 years has the Proposed Insured been convicted of operating a motor vehicle while under the influence of alcohol or other drugs? .. | ___ | ___ |
| 38. Has the Proposed Insured ever been convicted of a felony, or is s/he currently on parole or probation? .. | ___ | ___ |

SECTION 4

Non-Medical Complete this section only if Proposed Insured is not being examined by MassMutual

39. Proposed Insured's Name _____ D.O.B. ___/___/___ S.S. # ___ - ___ - ___

40. Height _____ Weight _____ lb If weight changed by over 10 lb in the last year, indicate amount and reason

41. Name and address of Proposed Insured's personal physician

Name _____

Address _____

(phone number if known) _____

41a. Date last seen and reason: _____

42. Proposed Insured's Family History

Relative	Health Problems-Include age at onset (especially for cardiovascular disease)	Age if living	Age at death	Cause of Death
Father				
Mother				
Brother(s)/ Sister(s)				

If answer "Yes" to any of the following questions, circle applicable item and explain in area Remarks Section. IDENTIFY QUESTION & NUMBER/Give diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all health professionals. Supplement "A" may be attached if necessary to fully explain details.

43. Has Proposed Insured: Yes No

- a. smoked cigarettes during the last 12 months? ___ ___
- b. used tobacco or products containing nicotine within the last 12 months? ___ ___
- c. used tobacco or products containing nicotine within the last 24 months? ___ ___

44. In the last 10 years has Proposed Insured consulted a health professional regarding:

- a. chest pain, heart attack, high blood pressure, heart murmur, palpitations or any other disorder of the heart, arteries or veins? ___ ___
- b. a tumor or cancer including skin cancer, melanoma or colon polyps? ___ ___
- c. a disorder of the blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia or lymphoma? ___ ___
- d. a disorder of the brain, spinal cord or nervous system including seizures, tremors, paralysis, fainting, stroke or TIA (transient ischemic attack)? ___ ___
- e. depression, anxiety, stress, psychosis, suicide thoughts or attempts, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other emotional disorder? ___ ___

45. In the last 10 years, has Proposed Insured:

- a. used cocaine, barbiturates, narcotics, stimulants, hallucinogens or other controlled substances not prescribed by a physician? ___ ___
- b. received treatment, attended a program or been counseled for alcohol or drug abuse or been advised by a health professional to reduce the use of alcohol? ___ ___

46. In the last 5 years has Proposed Insured consulted a health professional regarding:

- a. a disorder of the eyes, ears, nose, throat? ___ ___
- b. asthma, shortness of breath, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), pneumonia, sleep apnea, or any other disorder of your respiratory system? ___ ___
- c. a disorder of the digestive system, liver, pancreas or gall bladder including hepatitis, jaundice, ulcers, intestinal bleeding, colitis, Crohn's disease (ileitis)? ___ ___
- d. a disorder or impairment of the muscles, bones, joints, nerves, including arthritis, gout, sciatica or amputations? ___ ___
- e. chronic fatigue syndrome, lupus or other rheumatologic disorder? ___ ___
- f. diabetes or a disorder of the thyroid, pituitary or adrenal glands? ___ ___
- g. a disorder of the kidneys, bladder, prostate or urinary tract or findings of sugar, protein or blood in the urine? ___ ___

Agreements and Signatures

The person(s) signing below acknowledge and agree that:

The Application – This is part of an application for life insurance. The application includes this Part 1A and its attached Census and Table of Temporary Insurance Rates, the Part 1B (which has been or which will be completed by the Proposed Insured), any Part 2 that may be required, and any amendments or supplements to either Part. To the best of the knowledge and belief of the person(s) signing below, all statements in this application are complete and true and were truly recorded. Each person signing below adopts all the statements made in the application and agrees to be bound by them. This Application (Part 1A) is valid until withdrawn by the Owner by written notice to us at our Home Office. Withdrawal of this Application (Part 1A) shall not necessarily affect its use with applications submitted prior to the date we receive such notice.

Beneficiary – Unless otherwise requested, surviving beneficiaries in any class shall take equally. If percentages or fractions are indicated and any beneficiary dies before the insured, payment shall be made proportionately to the surviving beneficiaries in that class. If no beneficiary is entitled to the payment at the time of claim, the proceeds shall be made to the owner, if living, or the owner’s estate.

Liability of Company – The insurance applied for will not take effect unless the first premium is paid during the lifetime of the person to be insured under the policy and the application must be approved by the insurer at its Home Office. The policy must be delivered to the Owner named in the policy and, at the time of payment and delivery, all statements made in this application related to the insurability of all persons to be insured under the policy must be complete and true as though they were made at that time.

Authority of Producers – No producer can change the terms of this application or any policy issued by the insurer. No producer can waive any of the insurer’s rights or requirements or extend the time for any payment.

Changes and Corrections – Any material change or correction of the application will be shown on an Amendment of Application attached to the policy. Acceptance of any policy issued shall be acceptance of any change or correction of the application made by the Company. However, any correction or change in the amount, classification, plan of insurance, or riders applied for in this application must be agreed to in writing.

Authorization to Obtain and Disclose Information (For The Insured And/Or Applicant) – I have received the notice about the Medical Information Bureau, Inc. (MIB). I have also received the notice about the Fair Credit Reporting Act. I understand and authorize an investigative report to be made. This report may include information about my character, general reputation, personal characteristics and mode of living. I hereby authorize certain parties that have any records or knowledge of me and my health to make such information available to Massachusetts Mutual Life Insurance Company and/or MML Bay State Life Insurance Company, their reinsurers, and MML Insurance Agency, Inc. These parties include: any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, the MIB, or other organization. I also authorize MassMutual, or its reinsurers, to disclose information about me to the MIB in the form of a brief coded report for participation in MIB’s fraud prevention and detection programs. I agree that the photocopy or facsimile of this authorization may be used to obtain information. (This authorization is only valid where permitted by law.)

ANY POLICY OR CERTIFICATE ISSUED AS A RESULT OF A MATERIAL MISSTATEMENT OR OMISSION OF FACTS MAY BE VOIDED, AND THE COMPANY’S ONLY OBLIGATION SHALL BE TO RETURN THE PREMIUMS PAID.

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 may be guilty of a crime and may be subject to fines and confinement in prison.

Taxpayer Identification – The Owner applied for herein certifies, under penalties of perjury, that (i) the number referred to in 2a of this application is his/her correct Taxpayer Identification Number (or he/she is waiting for a number to be issued); and (ii) he/she is not subject to backup withholding either because he/she has not been notified by the Internal Revenue Service (IRS) that he/she is subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified him/her that he/she is no longer subject to backup withholding, and (iii) the Owner is a U.S. person. [If the IRS has notified the Owner that he/she is subject to backup withholding and he/she has not received notice from the IRS that backup withholding has terminated, he/she should strike out language in (ii) above.]

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications to avoid backup withholding.

Signature of Proposed Insured _____ Date _____

Print name of Proposed Insured (Required)

Signature of Certificate Owner (if not Proposed Insured) _____ Date _____

(print name required)

Applicant, if not Owner: Insured Other _____ (print name required)

Signature of Applicant (if not Owner or Insured) _____ Date _____

Signature of Soliciting Agent/Producer _____ Signed at (city/state) _____

Print Soliciting Agent/Producer name _____ General Agent submitting application/Agency # (If any) _____

Replacement Information (Required)

Will the insurance now being applied for replace or change, or is it intended to replace or change, any insurance or annuity, in whole or in part, issued by this or any other company? Yes No

General Agent Submitting Application _____ Signature of Soliciting Producer _____

To the Company as defined below:

- Massachusetts Mutual Life Insurance Company**
1295 State Street, Springfield, Massachusetts 01111-0001
- MML Bay State Life Insurance Company**
1295 State Street, Springfield, Massachusetts 01111-0001
www.massmutual.com

Application (Part 1) FOR CHANGE TO LIFE INSURANCE POLICY

This is an application to change policy(ies) numbered _____
on the life(s) of _____.

Please do not remit premium with application.

In this application, each person named above is referred to as a "Proposed Insured."

A Policy Change(s) Requested	
<p>1. Increase Amount of Policy</p> <p><input type="checkbox"/> Variable Life and Universal Life Policies Amount of Increase \$ _____</p> <p>2. Add/Increase Rider(s)</p> <p><input type="checkbox"/> Add Rider(s)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Waiver of Premium/Monthly Charges (WMC)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Accidental Death Benefit (ADB) \$ _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Other: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>3. Other Policy Change(s)</p> <p><input type="checkbox"/> Change Risk Class <input type="checkbox"/> Rating Adjustment</p> <p style="margin-left: 20px;"><input type="checkbox"/> Smoker to Nonsmoker/Tobacco to Nontobacco <i>(If no other changes, complete only item 8.)</i></p> <p style="margin-left: 20px;"><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Change Death Benefit Option to: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p><input type="checkbox"/> Change Basic Plan of Insurance to: _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Other: _____</p> <p><i>This application may not be used to reduce the Face Amount of a policy.</i></p> <p>4. For Changes to Variable Life and Universal Life Policies</p> <p><input type="checkbox"/> Change Planned Premium to: \$ _____</p> <p><input type="checkbox"/> Change Planned Premium Frequency to:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly</p> <p style="margin-left: 20px;"><input type="checkbox"/> Other: _____</p>

B Other Insurance/Replacement Information																
<p>5. Replacement/Section 1035 Exchange (For each policy listed below, include completed replacement forms with this application). <i>(Complete this item only if additional life insurance is being applied for with this application.)</i></p>																
<p>a. Life Insurance currently applied for, contemplated, or now in force on the Insured in other companies. If none, check here <input type="checkbox"/></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Company</th> <th style="width: 20%;">Year(s) Issued</th> <th style="width: 20%;">Product</th> <th style="width: 30%;">Amount</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		Company	Year(s) Issued	Product	Amount	_____	_____	_____	_____	_____	_____	_____	_____			
Company	Year(s) Issued	Product	Amount													
_____	_____	_____	_____													
_____	_____	_____	_____													
<p>a. Total amount of new insurance to be placed currently in all companies \$ _____.</p>																
<p>b. Is the insurance now being applied for intended to replace or change any insurance or annuity, in whole or part, issued by this or another company? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete information below:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Company</th> <th style="width: 20%;">Policy Number</th> <th style="width: 20%;">Product</th> <th style="width: 15%;">Amount</th> <th style="width: 25%;">1035 Exchange</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Company	Policy Number	Product	Amount	1035 Exchange	_____	_____	_____	_____	<input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/>
Company	Policy Number	Product	Amount	1035 Exchange												
_____	_____	_____	_____	<input type="checkbox"/>												
_____	_____	_____	_____	<input type="checkbox"/>												

C Personal Data Regarding Proposed Insured(s)

- 6. Has the Proposed Insured:**
- a. In the last 3 years applied for life insurance and been declined, postponed, rated, or restricted? Y N
 - b. In the last year had a physical exam, check-up or evaluation by a health professional? Y N
(If "Yes," provide diagnosis or findings in Details below.)
 - c. In the last 3 years consulted a health professional regarding a diagnosis of Human Immunodeficiency Virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS)? Y N
 - d. In the last 3 years been, or now expect to become, a pilot, student pilot, or crew member of any type of aircraft? **(If "Yes," complete Aviation Supplement.)** Y N
 - e. In the last 3 years taken part in, or now expect to take part in, underwater diving, hang gliding, para sailing, para kiting, parachuting, skydiving, mountain climbing, or organized racing by automobile, motorcycle, motorboat, or snowmobile, bungee jumping, helicopter skiing, and other extreme sports, or any other form(s) of hazardous activity? Y N
(If "Yes," complete Avocation Supplement.)
 - f. Within the last 5 years, been in a motor vehicle accident, been convicted of a moving violation, or received a driver's license restriction or revocation? Y N
 - g. Within the last 10 years, been convicted of operating a motor vehicle while under the influence of alcohol or other drugs? Y N
 - h. Ever been convicted of a felony, or is he/she currently on parole or probation? Y N
 - i. Ever been actively at work on a full-time basis beginning with and during the 90 days prior to the date of signing this application Part 1B? "Actively at work" means working full time at a rate of at least 30 hours per week with no hospitalization and no absence due to illness or accident of more than 5 consecutive business days or a cumulative total of 7 days? Y N
(If "No," give detailed explanation in Remarks section.)

7. Does the Proposed Insured now anticipate foreign travel? Y N
(If "Yes," complete the Foreign Travel Supplement.)

- 8. Has the Proposed Insured:**
- a. Smoked cigarettes in the past 12 months? Y N
 - b. If "No," has the Proposed Insured used tobacco or nicotine in any other form in the past 12 months? Y N
 - c. Used tobacco or nicotine in any form during the past 24 months? Y N
 - d. Ever been treated for, or been diagnosed by a member of the medical profession as having, emphysema, chronic bronchitis, persistent cough, shortness of breath, persistent hoarseness, cancer (type: _____), stroke, heart disorder, blood vessel disease, or disease of the heart, lung, liver, kidney, or nervous system? Y N

9. Provide following information:

Occupation	Exact Duties	Current Driver's License No. and State

Remarks Section
Give diagnosis and symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all health professionals.

D Agreements and Signatures

Each person signing below agrees that:

The Application – This is Part 1 of application for life insurance. The application includes any Part 2 that may be required and any amendments and supplements to either Part. To the best of the knowledge and belief of each person signing below, all statements in this Part 1 are complete and true and were correctly recorded before signing. Each person signing below adopts all statements made in this application and agrees to be bound by them. It is understood that the Company reserves the right to request additional information.

Company, as used in this Application, refers to Massachusetts Mutual Life Insurance Company and/or MML Bay State Life Insurance Company.

Authority of Agents – No agent can change the terms of this application. No agent can waive any of the Company’s rights or requirements, or extend the time for any payment.

Authorization to Obtain and Disclose Information (for the insured(s) and/or Applicant) – As a proposed insured, I, by my signature below, acknowledge that I have received the notice about the Medical Information Bureau, Inc. (MIB). I have also received the notice about the Fair Credit Reporting Act. I understand and authorize an investigative report to be made. This report may include information about my character, general reputation, personal characteristics, and mode of living. I hereby authorize certain parties that have records or knowledge of me and my health (or my children and their health if juvenile insurance), to make such information available to the Company, its reinsurers, and MML Insurance Agency, Inc., and its Companies. These parties include: any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, the MIB, the Department of Motor Vehicles or other organizations. I also authorize MassMutual, or its reinsurers, to disclose information about me to the MIB in the form of a brief coded report for participation in MIB’s fraud prevention and detection programs. I agree that a photocopy or facsimile of this authorization may be used to obtain information. This release shall be valid for 26 months from its date.

Fraud Notice – Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim or provides false, incomplete, or misleading information as part of the information provided to obtain coverage commits a fraudulent act, which is a crime and may be subject to criminal and civil penalties. Any policy issued as a result of material misstatement or omission of facts may be voided and the company’s only obligation shall be to return the premiums paid.

PLEASE CONSULT YOUR POLICY TO DETERMINE THE EFFECTIVE DATE OF ANY POLICY CHANGE REQUESTED HEREIN.

Signed on _____
(Date)

X _____
Signature of Proposed Insured 1 (if under age 16, parent)

X _____
Signature of Owner/Applicant (of new policy) Include Title (if applicable)
(Only if other than Proposed Insured)

City and State where Owner/Applicant signed

X _____
Signature of Soliciting Producer Agency #

X _____
Print Soliciting Producer Name

Thank you for choosing MassMutual for your Life Insurance needs. We value your business.

SURVEY

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

Client Data

1. Client ID (if known): _____

2. Proposed Insured's Name: first name _____ middle name _____
 (hereinafter referred to as the Insured) last name _____ suffix _____

3. Current Address: street & no. _____ city _____ state _____ zip _____ (e.g. Jr., III)
 mo. _____ day _____ yr. _____

4. Soc. Sec. No.: _____

5. Male Female

6. Birthplace: _____

7. Date of Birth: _____

8. Citizenship, if not USA: _____ Type of Visa Perm. Temp.

9. What is his/her Occupation(s) and Exact Duties?
 Occupation(s) _____ Exact Duties _____

Product Data

10. (a) Life Insurance:
 Whole Life
 Limited Pay WL _____
 Enhanced Whole Life
 APT
 Variable Life Plus
 Universal Life

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

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

11. (a) Disability and BOE Insurance:
 Disability Income (DI or TD) Business Overhead Expense
 Conditionally Renewable Disability Income (CR or TCR)

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

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

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

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

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

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

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

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

Personal Information

12. Reason Survey being submitted: _____

13. Insured's Income:

Annual Earned Income \$ _____ Annual Unearned Income \$ _____

14. Is there now, or has the Insured had, any illness, sickness, injury or impairment of health? Yes No
 (If "Yes", complete below for each illness, injury or impairment of health.)

A.	Diagnosis	Medication/Treatment	Still Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	# of Attacks/ Occurrences	Dates (mo/yr) Onset Recovery

Physician/Medical Facility Name	Address	Zip

B.	Diagnosis	Medication/Treatment	Still Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	# of Attacks/ Occurrences	Dates (mo/yr) Onset Recovery

Physician/Medical Facility Name	Address	Zip

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

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

If "Yes" to any questions, please explain in 20 below.

	Yes	No
17. Have any of his/her parents, brothers or sisters: (a) had cardiovascular disease prior to age 60?.....	<input type="checkbox"/>	<input type="checkbox"/>
(b) ever had diabetes, kidney disease, or other familial disorder?	<input type="checkbox"/>	<input type="checkbox"/>
18. Has he/she smoked cigarettes in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
19. Has he/she applied for life or health insurance and been declined, postponed, rated or restricted in the last ten years?	<input type="checkbox"/>	<input type="checkbox"/>

20. Question Number	Explanatory Details and Remarks

21. Within the last 3 years has he/she been or does he/she now expect to become, a pilot, student pilot or crew member of any type of aircraft? If "Yes", complete Aviation Supplement A3310..... Yes No

22. Within the last 3 years has he/she or does he/she now expect to take part in underwater diving, hang gliding, para sailing, para kiting, parachuting, skydiving, mountain climbing or organized racing by automobile, motorcycle, motorboat or snowmobile? If "Yes", complete Avocation Supplement A3320 Yes No

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

SERFF Tracking #:

MASS-128699418

State Tracking #:

Company Tracking #:

MIB AUTHORIZATION

State:

Arkansas

Filing Company:

Massachusetts Mutual Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

MIB Authorization Update

Project Name/Number:

/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:	Attached		
Attachment(s):			
AR Readability Cert.pdf			

READABILITY CERTIFICATION

I hereby certify the accuracy of the Flesch reading ease test score for the following policy forms. These forms are at least 10 (ten) point type, 2 (two) point leaded.

FORM NUMBER AND TITLE

FLESCH SCORE

A70AR912	Application Part 1 - For Individual Term Life Insurance	50.4
A3200-9000 0912	Application (Part 1)	55.2
A3050-9000 0912	Survey Application	56.3
A3820-2012	Application Part 1B	52.7
LCM-2012	Application (Part 1) For Change To Life Insurance Policy	53.5

Signature:

Jo-Anne Rankin

Digitally signed by Jo-Anne Rankin
DN: cn=Jo-Anne Rankin, o=MM USIG,
ou=Reinsurance, Filing, Illustrations,
email=jrankin@massmutual.com, c=US
Date: 2012.10.01 17:15:41 -0400

Jo-Anne Rankin

Vice President & Actuary

Date:

9/27/12