

State: Arkansas **Filing Company:** Massachusetts Mutual Life Insurance Company
TOI/Sub-TOI: L09G Group Life - Flexible Premium Adjustable Life/L09G.001 Single Life
Product Name: Executive Group Life
Project Name/Number: MIB Authorization/

Filing at a Glance

Company: Massachusetts Mutual Life Insurance Company
Product Name: Executive Group Life
State: Arkansas
TOI: L09G Group Life - Flexible Premium Adjustable Life
Sub-TOI: L09G.001 Single Life
Filing Type: Form
Date Submitted: 10/18/2012
SERFF Tr Num: MASS-128723335
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation: On Approval
Date Requested:
Author(s): Steven Miller, Robin Perez, Diana Violette, Jennifer Dube
Reviewer(s): Linda Bird (primary)
Disposition Date: 10/24/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas Filing Company: Massachusetts Mutual Life Insurance Company
 TOI/Sub-TOI: L09G Group Life - Flexible Premium Adjustable Life/L09G.001 Single Life
 Product Name: Executive Group Life
 Project Name/Number: MIB Authorization/

General Information

Project Name: MIB Authorization Status of Filing in Domicile: Not Filed
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Small and Large
 Group Market Type: Discretionary Overall Rate Impact:
 Filing Status Changed: 10/24/2012
 State Status Changed: 10/24/2012 Deemer Date:
 Created By: Diana Violette Submitted By: Diana Violette
 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 GULSF-2012 and GULSFNV-2012 are Employee or Spouse Applications (Part 1B) and will replace GULSF-2002 and GULSFNV-2002 which were approved on 4/12/2002. The INCSI-2012 is a Certificate Increase application and will replace INCSI-2004 which was approved on 1/11/2005. These applications will be used by Massachusetts Mutual Life Insurance Company. 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: Massachusetts
 1295 State Street Group Code: 435 Company Type:
 MIP: M381 Group Name: State ID Number:
 FEIN Number: 04-1590850
 Springfield, MA 01111
 (800) 767-1000 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$225.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

Company	Amount	Date Processed	Transaction #
Massachusetts Mutual Life Insurance Company	\$225.00	10/18/2012	64034283

SERFF Tracking #:

MASS-128723335

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Massachusetts Mutual Life Insurance Company

TOI/Sub-TOI:

L09G Group Life - Flexible Premium Adjustable Life/L09G.001 Single Life

Product Name:

Executive Group Life

Project Name/Number:

MIB Authorization/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/24/2012	10/24/2012

SERFF Tracking #:

MASS-128723335

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Massachusetts Mutual Life Insurance Company

TOI/Sub-TOI:

L09G Group Life - Flexible Premium Adjustable Life/L09G.001 Single Life

Product Name:

Executive Group Life

Project Name/Number:

MIB Authorization/

Disposition

Disposition Date: 10/24/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application		No
Supporting Document	Flesch Certification		Yes
Supporting Document	Health - Actuarial Justification		No
Form	Application Part 1B		Yes
Form	Application Part 1B		Yes
Form	Increase Application		Yes

SERFF Tracking #:

MASS-128723335

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

Massachusetts Mutual Life Insurance Company

TOI/Sub-TOI: L09G Group Life - Flexible Premium Adjustable Life/L09G.001 Single Life

Product Name: Executive Group Life

Project Name/Number: MIB Authorization/

Form Schedule

Lead Form Number: GULSF-2012

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		GULSF-2012	AEF	Application Part 1B	Initial:	52.500	gulsf-2012.pdf
2		GULSFNV-2012	AEF	Application Part 1B	Initial:	50.000	gulsfnv-2012.pdf
3		INCSI-2004	AEF	Increase Application	Initial:	52.000	incsi-2012.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

EMPLOYEE OR SPOUSE APPLICATION (Part 1B)
Strategic Edge Group Flexible Premium Variable Adjustable Life Insurance
(GVUL)

Massachusetts Mutual Life Insurance Co.
Home and Principal Administrative Office:
Springfield, Massachusetts 01111-0001

Simplified Issue (Complete Sections 1 & 2)
Full Underwriting (Complete Sections 1 & 3)

SECTION 1

Employer Data

1. Employer Name: _____
2. Coverage Selection: *(Select only one)*
_____ Employee Coverage _____ Spouse Coverage
- (Fill out either the Employee-Proposed Insured Data or Spouse-Proposed Insured Data section below based on box checked above.)*

Employee's Proposed Insured Data

3. Employee's Name: *(Last, First, MI)* _____
4. a. Employee's Address: *(No. & Street, City, State, Zip)* _____

- b. Employee's Phone Number: _____
5. Gender: _____ Male _____ Female 6. Date of Birth (Mo./Day/Yr.) _____
- 7a. Employee's Social Security Number: _____
- 7b. Citizenship, if not USA: _____ Type of Visa: _____ Permanent _____ Temporary
8. Employee's Regular Place of Work: _____
(No. & Street, City, State, Zip)

Spouse's Proposed Insured Data (Complete this section if applying for spousal coverage)

9. a. Spouse's Name: *(Last, First, MI)* _____
b. Employee's Name: *(Last, First, MI)* _____
10. a. Spouse's Address: *(No. & Street, City, State, Zip)* _____

- b. Spouse's Phone Number: _____
11. Gender: _____ Male _____ Female 12. Date of Birth (Mo./Day/Yr.) _____
13. Spouse's Social Security Number: _____
14. Citizenship, if not USA: _____ Type of Visa: _____ Permanent _____ Temporary

Proposed Insured Name: _____

Life Insurance Data

15. Selected Face Amount: \$ _____
16. Variable Rider Option Yes No If "Yes", a Supplement to Application/Enrollment Form must be completed.
17. Beneficiary (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 Proposed 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 Proposed Insured dies and the Proposed Insured is the Owner at that time, payment shall be made to the estate of the Proposed Insured; but if the Proposed Insured is not the Owner, payment shall be made to the Owner.*
18. a. Full Name and Address of the Owner (if not the insured): _____

- b. Owner's Tax ID Number/Social Security Number: _____
19. Has the Employee been actively at work on a full-time basis beginning with and during the 90 days prior to the date of his/her signing this Part 1B application? "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," explain in Remarks section.**
20. Is the Proposed Insured currently receiving or applying to receive disability compensation? Yes No
If "Yes," explain in Remarks section.
21. Has the Proposed Insured smoked cigarettes in the last 12 months? Yes No
If "Yes," specify in Remarks section
22. Is the insurance now being applied for intended to replace or change any individual insurance or annuity, in whole or in part, issued by this or any other company? Yes No
If "Yes," give company name, policy number, amount in Remarks section.

SECTION 2

Simplified Issue

Underwriting Data

23. Have you 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)?
 Yes No
24. Have you 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? Yes No
25. Have you applied for life insurance and been declined, rated, restricted or postponed in the last 10 years?
 Yes No
- If "Yes" answers given in 23, 24, or 25, give details in Remarks section.**

Proposed Insured Name: _____

SECTION 3

Full Underwriting

Underwriting Data

**Please submit appropriate completed Part 2 form.
Explain "Yes" answers in Remarks section.**

26. 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 of Issue	Application Pending

27. List all occupations and the exact duties of each.

Occupation(s)	Exact Duties

28. Proposed Insured's net worth: \$ _____ 29. Proposed Insured's income: \$ _____

30. Spouse's income \$ _____ (If spousal coverage)

31. Does the Proposed Insured anticipate any foreign travel? _____ Yes _____ No

32. Within the last three years has the Proposed Insured been or does the Proposed Insured now expect to become a pilot, student pilot, or crew member of any type of aircraft? _____ Yes _____ No

If "Yes," submit Aviation Supplement A3310.

33. Within the last three years has the Proposed Insured taken part in, or does the Proposed Insured 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, or any other forms of hazardous activity?
_____ Yes _____ No **If "Yes," submit Avocation Supplement A3320.**

34. Within the last five years has the Proposed Insured been in a motor vehicle accident, been convicted of operating a motor vehicle while under the influence of alcohol or other drugs, been convicted of a moving violation, or received a driver's license restriction or revocation? _____ Yes _____ No

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

36. Has the Proposed Insured been convicted of a felony? _____ Yes _____ No

Proposed Insured Name: _____

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 Medical Information Bureau, Inc. 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 Medical Information Bureau, Inc., or other organization that has any records or knowledge of me and my health, to make such information available to the life insurance company or its reinsurers. Kcnuq"cwj qtk g'O cuuO wwn"qt'ku" tglpuwtgu."v"f kærug"lphqto cvkqp"cdqw'o g'\q"vj g'O Kp"lp"vj g'hqto "qh'c"dtlgh'eqf gf 'tgr qtv'hqt'r ctvek cvkqp'lp'O KDu'htcwf " r tngxgpvkqp"cpf "f gvevkqp'r tqi tco u0A copy of this authorization shall be as valid as the original and I realize that I am entitled to receive a copy of this authorization. (This authorization is only valid where permitted by state law.)

Taxpayer Identification (Applies only if Proposed Insured is Owner) – The Proposed Insured herein certifies, under penalties of perjury, that: (i) the number referred to in no. 7 or no. 13 of this Part 1B 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 because the IRS has notified him/her that he/she is no longer subject to backup withholding. **If the IRS has notified the Proposed Insured 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 above in (ii) that he/she is not subject to backup withholding due to notified payee underreporting.**

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.

Signature of Proposed Insured

Signature of Registered Representative/Agent or Authorized Enroller

Print Registered Representative/Agent or Authorized Enroller Name

Signature of Owner (if different from Proposed Insured)

Signed at _____ on _____
City State Date

EMPLOYEE OR SPOUSE APPLICATION (Part 1B)
Strategic Edge Group Flexible Premium Adjustable Life Insurance

Massachusetts Mutual Life Insurance Co.
Home and Principal Administrative Office:
Springfield, Massachusetts 01111-0001

Simplified Issue (Complete Sections 1 & 2)
Full Underwriting (Complete Sections 1 & 3)

SECTION 1

Employer Data

1. Employer Name: _____
2. Coverage Selection: *(Select only one)*
_____ Employee Coverage _____ Spouse Coverage
- (Fill out either the Employee-Proposed Insured Data or Spouse-Proposed Insured Data section below based on box checked above.)*

Employee's Proposed Insured Data

3. Employee's Name: *(Last, First, MI)* _____
4. a. Employee's Address: *(No. & Street, City, State, Zip)* _____

- b. Employee's Phone Number: _____
5. Gender: _____ Male _____ Female 6. Date of Birth (Mo./Day/Yr.) _____
- 7a. Employee's Social Security Number: _____
- 7b. Citizenship, if not USA: _____ Type of Visa: _____ Permanent _____ Temporary
8. Employee's Regular Place of Work: _____
(No. & Street, City, State, Zip)

Spouse's Proposed Insured Data (Complete this section if applying for spousal coverage)

9. a. Spouse's Name: *(Last, First, MI)* _____
- b. Employee's Name: *(Last, First, MI)* _____
10. a. Spouse's Address: *(No. & Street, City, State, Zip)* _____

- b. Spouse's Phone Number: _____
11. Gender: _____ Male _____ Female 12. Date of Birth (Mo./Day/Yr.) _____
13. Spouse's Social Security Number: _____
14. Citizenship, if not USA: _____ Type of Visa: _____ Permanent _____ Temporary

Proposed Insured Name: _____

Life Insurance Data

15. Selected Face Amount: \$ _____

16. Beneficiary (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 Proposed 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 Proposed Insured dies and the Proposed Insured is the Owner at that time, payment shall be made to the estate of the Proposed Insured; but if the Proposed Insured is not the Owner, payment shall be made to the Owner.

17. a. Full Name and Address of the Owner (if not the insured): _____

b. Owner's Tax ID Number/Social Security Number: _____

18. Has the Employee been actively at work on a full-time basis beginning with and during the 90 days prior to the date of his/her signing this Part 1B application? "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," explain 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. Is the insurance now being applied for intended to replace or change any individual insurance or annuity, in whole or in part, issued by this or any other company? _____ Yes _____ No
If "Yes," give company name, policy number, amount in Remarks section.

SECTION 2

Simplified Issue

Underwriting Data

22. Have you 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)?
_____ Yes _____ No

23. Have you 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? _____ Yes _____ No

24. Have you applied for life insurance and been declined, rated, restricted or postponed in the last 10 years?
_____ Yes _____ No

If "Yes" answers given in 22, 23, or 24, give details in Remarks section.

Proposed Insured Name: _____

SECTION 3

Full Underwriting

Underwriting Data

**Please submit appropriate completed Part 2 form.
Explain "Yes" answers in Remarks section.**

25. 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 of Issue	Application Pending

26. List all occupations and the exact duties of each.

Occupation(s)	Exact Duties

27. Proposed Insured's net worth: \$ _____ 28. Proposed Insured's income: \$ _____

29. Spouse's income \$ _____ (If spousal coverage)

30. Does the Proposed Insured anticipate any foreign travel? _____ Yes _____ No

31. Within the last three years has the Proposed Insured been or does the Proposed Insured now expect to become a pilot, student pilot, or crew member of any type of aircraft? _____ Yes _____ No

If "Yes," submit Aviation Supplement A3310.

32. Within the last three years has the Proposed Insured taken part in, or does the Proposed Insured 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, or any other forms of hazardous activity?
_____ Yes _____ No **If "Yes," submit Avocation Supplement A3320.**

33. Within the last five years has the Proposed Insured been in a motor vehicle accident, been convicted of operating a motor vehicle while under the influence of alcohol or other drugs, been convicted of a moving violation, or received a driver's license restriction or revocation? _____ Yes _____ No

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

35. Has the Proposed Insured been convicted of a felony? _____ Yes _____ No

Proposed Insured Name: _____

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 Medical Information Bureau, Inc. 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 Medical Information Bureau, Inc., or other organization that has any records or knowledge of me and my health, to make such information available to the 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 and I realize that I am entitled to receive a copy of this authorization. (This authorization is only valid where permitted by state law.)

Taxpayer Identification (Applies only if Proposed Insured is Owner) – The Proposed Insured herein certifies, under penalties of perjury, that: (i) the number referred to in no. 7 or no. 13 of this Part 1B 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 because the IRS has notified him/her that he/she is no longer subject to backup withholding. **If the IRS has notified the Proposed Insured 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 above in (ii) that he/she is not subject to backup withholding due to notified payee underreporting.**

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.

Signature of Proposed Insured

Signature of Registered Representative/Agent or Authorized Enroller

Signature of Owner (if different from Proposed Insured)

Print Registered Representative/Agent or Authorized Enroller Name

Signed at _____ City _____ State _____ on _____ Date



Certificate Increase Application Form

Strategic Edge Group Flexible Premium Adjustable Life Insurance
Strategic Edge Group Flexible Premium Variable Adjustable Life Insurance
(GUL/GVUL)

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

➤ Employer Data

1. Employer Name: _____
2. Group Number: _____

➤ Insured Data

3. Insured's Name: (Last, First, MI) _____
4. Insured's Resident Address: (No. & Street, City, State, Zip) _____
5. Insured's Certificate Number: _____
6. Insured's Date of Birth: (Mo/Day/Yr) _____
7. Insured's Social Security Number or TIN#: _____

➤ Increase Requested

8. Current Selected Face Amount: \$ _____ Requested Selected Face Amount: \$ _____

➤ Underwriting Information

9. Has the Insured been actively at work on a full-time basis beginning with and during the 90 days prior to the date of signing this Certificate Increase Application form? "Actively at work" means A) working full time at a rate of at least 30 hours per week with no hospitalization; and B) no absence due to illness or accident of more than five (5) consecutive days or a cumulative total of seven (7) days. Yes No
10. Is the Insured currently receiving or applying to receive disability compensation? Yes No
11. Has the 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)? Yes No
12. Has the 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, liver, brain or nervous system? Yes No
13. Has the Insured applied for life insurance and been declined, rated, restricted or postponed in the last 10 years?
 Yes No

If a "No" answer is given in # 9, or a "Yes" answer is given in #'s 10, 11, 12 or 13, you must provide details in Remarks section below.

➤ Remarks

Question #	Explanation

➤ Acknowledgement and Signature

This is an application for an increase in Selected Face Amount. If approved, the increase will be effective on the monthly calculation date which is on, or next follows, the later of A) 15 days after our approval, or B) the requested effective date of the change. To the best of the knowledge and belief of each person signing below, all statements in this application form are complete and true and were correctly recorded.

Authorization to Obtain and Disclose Information – 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, its 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 a photocopy or facsimile of this authorization may be used to obtain information. (This authorization is only valid where permitted by law.)

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.

Signature of Insured _____ Date _____

Signature of Owner (if different from Insured) _____ Date _____

SERFF Tracking #:

MASS-128723335

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Massachusetts Mutual Life Insurance Company

TOI/Sub-TOI:

L09G Group Life - Flexible Premium Adjustable Life/L09G.001 Single Life

Product Name:

Executive Group Life

Project Name/Number:

MIB Authorization/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:	Readability attached		
Attachment(s):	AR Certif of Compliance with Rule 19.pdf AR Readability Cert.pdf		

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Massachusetts Mutual Life Insurance Company

Form Number(s): GULSF-2012
GULSFNV-2012
INCSI-2012

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

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: 2012.10.18 12:59:13 -04'00'

Signature of Company Officer

Jo-Anne Rankin

Name

Vice President & Actuary

Title

10/18/2012

Date

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.

<u>FORM NUMBER AND TITLE</u>		<u>FLESCH SCORE</u>
GULSF-2012	Application Part 1B – Employee or Spouse	52.5
GULSFNV-2012	Application (Part 1B – Employee or Spouse	50.0
INCSI-2012	Increase Application	52.0

Signature:  Jo-Anne Rankin
Jo-Anne Rankin
Vice President & Actuary

Date: 10/18/2012

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: 2012.10.18 12:59:50 -0400'