

SERFF Tracking Number: BSTN-128078019 State: Arkansas
Filing Company: Boston Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: IND-12-001
TOI: L02I Individual Life - Endowment Sub-TOI: L02I.001 Single Life - Fixed/Indeterminate Premium
Product Name: Individual Endowment at age 98 Simplified Underwriting Application
Project Name/Number: GA Simplified Application/IND-12-001

Filing at a Glance

Company: Boston Mutual Life Insurance Company

Product Name: Individual Endowment at age 98 SERFF Tr Num: BSTN-128078019 State: Arkansas

Simplified Underwriting Application

TOI: L02I Individual Life - Endowment

SERFF Status: Closed-Approved-
Closed State Tr Num:

Sub-TOI: L02I.001 Single Life -
Fixed/Indeterminate Premium

Co Tr Num: IND-12-001

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Peggy Schwartz, Kathy
Padis

Disposition Date: 02/15/2012

Date Submitted: 02/08/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: GA Simplified Application

Project Number: IND-12-001

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Kathy Padis

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 01/31/2012

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 02/15/2012

State Status Changed: 02/15/2012

Created By: Kathy Padis

Corresponding Filing Tracking Number: IND-12-
001

Filing Description:

RE: Boston Mutual Life Insurance Company

NAIC # 61476 FEIN #04-1106240

Individual Life Insurance Application Form:

Form #: NB1 SF 4/11

SERFF Tracking Number: BSTN-128078019 State: Arkansas
Filing Company: Boston Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: IND-12-001
TOI: L021 Individual Life - Endowment Sub-TOI: L021.001 Single Life - Fixed/Indeterminate
Premium

Product Name: Individual Endowment at age 98 Simplified Underwriting Application

Project Name/Number: GA Simplified Application/IND-12-001

Company Filing No: IND-12-001

Enclosed for your approval is application NB1 SF 4/11. This is a new form and does not replace any existing forms. The application is a simplified underwriting application that will be used to write simplified coverage for one insured with previously approved policy E-98 10/07 only. Approval information for this policy is included in this filing.

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

This form has been filed and approved through the Interstate Compact and under the compact the form is approved for use in our state of domicile, Massachusetts as of 1/31/12.

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

Fee Required? Yes
Fee Amount: \$75.00
Retaliatory? Yes
Fee Explanation: The fee for this filing would be higher in Massachusetts so the Massachusetts' fee will be the one charged.
Per Company: No

SERFF Tracking Number: *BSTN-128078019* State: *Arkansas*
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Company Tracking Number: *IND-12-001*
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Product Name: *Individual Endowment at age 98 Simplified Underwriting Application*
Project Name/Number: *GA Simplified Application/IND-12-001*

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|--------------------------------------|---------|----------------|---------------|
| Boston Mutual Life Insurance Company | \$75.00 | 02/08/2012 | 56184516 |

SERFF Tracking Number: *BSTN-128078019* State: *Arkansas*
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Product Name: *Individual Endowment at age 98 Simplified Underwriting Application*
Project Name/Number: *GA Simplified Application/IND-12-001*

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|-------------------|-------------------|-----------------------|
| Approved-Closed | Linda Bird | 02/15/2012 | 02/15/2012 |

SERFF Tracking Number: *BSTN-128078019* *State:* *Arkansas*
Filing Company: *Boston Mutual Life Insurance Company* *State Tracking Number:*
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TOI: *L021 Individual Life - Endowment* *Sub-TOI:* *L021.001 Single Life - Fixed/Indeterminate*
Premium
Product Name: *Individual Endowment at age 98 Simplified Underwriting Application*
Project Name/Number: *GA Simplified Application/IND-12-001*

Disposition

Disposition Date: 02/15/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *BSTN-128078019* State: *Arkansas*
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 Company Tracking Number: *IND-12-001*
 TOI: *L021 Individual Life - Endowment* Sub-TOI: *L021.001 Single Life - Fixed/Indeterminate Premium*
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 Project Name/Number: *GA Simplified Application/IND-12-001*

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|----------------------------|--------------------------------|-----------------------------|----------------------|
| Supporting Document | Flesch Certification | | Yes |
| Supporting Document | Application | | No |
| Supporting Document | Life & Annuity - Acturial Memo | | No |
| Supporting Document | Cover Letter | | Yes |
| Supporting Document | Approval Date for E-98 Policy | | Yes |
| Form | GA Simplified Application | | Yes |

SERFF Tracking Number: *BSTN-128078019* *State:* *Arkansas*
Filing Company: *Boston Mutual Life Insurance Company* *State Tracking Number:*
Company Tracking Number: *IND-12-001*
TOI: *L021 Individual Life - Endowment* *Sub-TOI:* *L021.001 Single Life - Fixed/Indeterminate Premium*

Product Name: *Individual Endowment at age 98 Simplified Underwriting Application*
Project Name/Number: *GA Simplified Application/IND-12-001*

Form Schedule

Lead Form Number: NB1 SF 4/11

| Schedule Item Status | Form Number | Form Type Form Name | Action | Action Specific Data | Readability | Attachment |
|-----------------------------|--------------------|--|---------------|-----------------------------|--------------------|--------------------------|
| | NB1 SF 4/11 | Application/ GA Simplified Enrollment Application Form | Initial | | 68.200 | 914-071 STND (3) (2).pdf |



BOSTON MUTUAL LIFE INSURANCE COMPANY
APPLICATION FOR SIMPLIFIED ISSUE INDIVIDUAL LIFE INSURANCE
 120 ROYALL STREET · CANTON, MASSACHUSETTS 02021-9968
 New Business Fax: 877-366-3036 or 781-770-0441

1st Agent _____ 2nd Agent _____

Agent # _____

Payroll # _____

| | | | | | | |
|---|----------------------|---|--|---|--|---|
| 1. Primary Proposed Insured's Name (Last, First, MI) | | Maiden Name | Sex M <input type="checkbox"/> F <input type="checkbox"/> | Date of Birth <small>Month Day Year</small> | Age <small>Nearest DOB</small> | Place of Birth |
| Primary Insured's Social Security # | Employer | Occupation | Monthly Income | Height & Weight _____ ft. _____ in. _____ lbs. | | |
| Primary Insured Residence Address (required) Number & Street - City - State - Zip | | | | | Marital Status <input type="checkbox"/> married <input type="checkbox"/> single | APL <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Amt. of Insurance \$ | Premium Amount \$ | Mailing Address if Other than Residence: Number & Street - City - State - Zip | | | | |
| Daytime Phone # | Evening Phone # | Cell Phone # | Best Time | Accidental Death Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ | Waiver of Premium <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Primary Beneficiary: (Name, Address & Relationship) | | | Social Security Number - - | Date of Birth <small>Month Day Year</small> | Age | |
| Contingent Beneficiary: (Name, Address & Relationship) | | | Social Security Number - - | Date of Birth <small>Month Day Year</small> | Age | |
| Primary Proposed Insured E-mail: | | | Spouse E-mail: | | | |

| | | | | | |
|---|--|---|---|--|-----------------------------------|
| 2. Spouse Name (If applying for individual coverage) | | Relationship to Owner | Sex M <input type="checkbox"/> F <input type="checkbox"/> | Date of Birth <small>Month Day Year</small> | Age <small>Nearest DOB</small> |
| Place of Birth | Spouse Social Security Number - - | Height & Weight _____ ft. _____ in. _____ lbs. | APL <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Spouse Address if different from Owner: | | Daytime Phone # | Evening Phone # | Best Time | |
| WP <input type="checkbox"/> Y <input type="checkbox"/> N | ADB <input type="checkbox"/> Y <input type="checkbox"/> N - Amt. \$ _____ | Spouse Employer & Address | | Spouse Occupation | Monthly Income \$ |
| Amt. of Insurance \$ | Premium Amt. \$ | Beneficiary Name & Address | | Social Security Number - - | Age Relationship |

| | | |
|--|--|---------------------------------|
| 3. <input type="checkbox"/> Owner <input type="checkbox"/> Payor for all Insureds (if other than Primary Insured) | Social Security Number - - | Relationship to Primary Insured |
| Owner/Payor Residence Address: Number & Street - City - State - Zip | | Owner/Payor DOB |
| Plan of Insurance for all Insureds | Mode of Premium for all Insureds: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC <input type="checkbox"/> Allotment* <input type="checkbox"/> Salary Deduction* Total Premium paid with application \$ _____ *Deduction: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly Total Modal Premium \$ _____ + PDF Amount \$ _____ = Total \$ _____ | |

| 4. SIMPLIFIED ISSUE QUESTIONS (Please refer to height & weight chart and age & amount guidelines) | | | |
|---|--|--|--|
| | Primary | Spouse ONLY | Children Rider ONLY-15 days up to age 18 years |
| 1. Have you used any form of tobacco or nicotine products in the past 12 months? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Are you a U.S. citizen? If anyone to be insured is NOT a U.S. citizen provide details: | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Are there any existing life insurance policies or annuity contracts currently in force or pending? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| a. How much insurance do you have in force or pending? _____ | | | |
| b. Will the policy applied for replace or change any insurance or annuities? If yes, submit any necessary replacement forms and give policy number, name and address of company. _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. Are you actively at work as of this date? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 5. Have you missed three or more consecutive days of work (for children: school) or normal activity due to illness or injury during the last 120 days? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 6. Have you within the past 10 years been diagnosed or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for antibodies to the AIDS virus (Human Immunodeficiency Virus)? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 7. Have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: Heart attack; Heart Bypass; Coronary Artery Disease; Congestive Heart Failure; Stroke; Cancer (other than Basal Skin Cancer); Chronic Obstructive Lung Disorder; COPD; Emphysema; Liver Disease; Kidney Failure; or Organ Transplant? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 8. Have you been hospitalized in the last 90 days or been advised by a member of the medical profession to seek: medical advice; treatment; care and/or counseling that has not yet been performed? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

If question 4 is answered "NO" and/or questions 5, 6, 7 and 8 are answered "YES" do not submit on Simplified Application.

- ACKNOWLEDGEMENTS -

To the best of my knowledge and belief, the statements in this application are complete and true. It is understood that if any statement is a material misrepresentation, coverage may be contested as a result. This application and any supplement shall form the basis for and become part of any policy issued. When the Company gives a Conditional Receipt coverage will start as shown in that form, provided the Company approves the application without any modification as to plan, amount or premium. If the application is approved with any such modification the insurance will not take effect until the policy has been delivered to and accepted by me and will not take effect if there has been a change in my health as stated in the application.

The agent has no authority to waive the answer to any question in or to modify the application.

Corrections and Amendments to be Accepted by Owner on Delivery of Contract.

CONSUMER REPORT AUTHORIZATION

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

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formally known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

MIB REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

**BOSTON MUTUAL LIFE INSURANCE COMPANY
AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION
(This authorization complies with the HIPAA Privacy Rule)**

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

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

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

"Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law."

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

| | |
|--|--|
| | |
|--|--|

Application Signed at City & State

Signature of Primary Proposed Insured

| | | |
|--|--|--|
| | | |
|--|--|--|

Date of Application

Signature of Other Proposed/Spouse Insured

Signature of Owner

| |
|--|
| |
|--|

Name and Address of Secondary Addressee

In order to satisfy our obligation under the USA PATRIOT Act, you may be asked to allow our agent to view your unexpired government issued picture ID. The verification process may also include the use of a third party source to confirm the information provided to us. Please be assured that this information will be treated with the highest regard for your privacy.

- BOSTON MUTUAL LIFE INSURANCE COMPANY -

CONDITIONAL RECEIPT

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

This acknowledges payment from _____ in the sum of \$ _____ in connection with a LIFE INSURANCE CONTRACT applied for from Boston Mutual Life Insurance Company. If Boston Mutual Life Insurance Company is satisfied that the Proposed Insured is eligible for insurance under its rules, at the time of application, then coverage will be effective from the date of the application.

| | |
|------|-------|
| Date | Agent |
|------|-------|

SERFF Tracking Number: *BSTN-128078019* State: *Arkansas*
 Filing Company: *Boston Mutual Life Insurance Company* State Tracking Number:
 Company Tracking Number: *IND-12-001*
 TOI: *L021 Individual Life - Endowment* Sub-TOI: *L021.001 Single Life - Fixed/Indeterminate Premium*
 Product Name: *Individual Endowment at age 98 Simplified Underwriting Application*
 Project Name/Number: *GA Simplified Application/IND-12-001*

Supporting Document Schedules

| | Item Status: | Status Date: |
|---|--------------|--------------|
| <p>Satisfied - Item: Flesch Certification Comments: Please find the Flesch Certification attached. Attachment: ReadabilityCert.pdf</p> | | |
| <p>Bypassed - Item: Application Bypass Reason: This is an Application Filing. Comments:</p> | | |
| <p>Bypassed - Item: Life & Annuity - Acturial Memo Bypass Reason: This is an Application Filing. Comments:</p> | | |
| <p>Satisfied - Item: Cover Letter Comments: Please find the Cover Letter attached. Attachment: CoverLetter.pdf</p> | | |
| <p>Satisfied - Item: Approval Date for E-98 Policy</p> | | |

SERFF Tracking Number: *BSTN-128078019* *State:* *Arkansas*
Filing Company: *Boston Mutual Life Insurance Company* *State Tracking Number:*
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TOI: *L021 Individual Life - Endowment* *Sub-TOI:* *L021.001 Single Life - Fixed/Indeterminate*
Premium
Product Name: *Individual Endowment at age 98 Simplified Underwriting Application*
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Comments:

The E-98 Policy was approved for use in Arkansas on 12/26/2007. The SERFF Tr # is: BSTN-125378442; State Tr #: 37669;



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

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

| FORM # | FLESCH SCORE |
|-------------|--------------|
| NB1 SF 4/11 | 68.2 |

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

Richard J. Miller

Richard J. Miller, JD
Director, Legal

Date: February 7, 2012



Peggy Schwartz, FLMI, ALHC, AIRC
Product Filing Manager

February 7, 2012

VIA SERFF

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

Company Filing No: IND-12-001

Enclosed for your approval is application NB1 SF 4/11. This is a new form and does not replace any existing forms. The application is a simplified underwriting application that will be used to write simplified coverage for one insured with previously approved policy E-98 10/07 only. Approval information for this policy is included in this filing.

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

This form has been filed and approved through the Interstate Compact and under the compact the form is approved for use in our state of domicile, Massachusetts as of 1/31/12.

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

Sincerely;

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