

SERFF Tracking Number: MASS-128229419 State: Arkansas
Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: FR2041GE
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: 2012 Change and Reinstatement Apps
Project Name/Number: 2012 Change and Reinstatement Apps/2012 Change and Reinstatement Apps

Filing at a Glance

Company: Massachusetts Mutual Life Insurance Company

Product Name: 2012 Change and Reinstatement Apps SERFF Tr Num: MASS-128229419 State: Arkansas

TOI: L08 Life - Other

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

Sub-TOI: L08.000 Life - Other

Co Tr Num: FR2041GE

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Robin Perez, Jennifer
Dube, Nick Sheehan

Disposition Date: 04/09/2012

Date Submitted: 04/03/2012

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2012 Change and Reinstatement Apps
Project Number: 2012 Change and Reinstatement Apps
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 04/09/2012

State Status Changed: 04/09/2012

Deemer Date:

Created By: Robin Perez

Submitted By: Robin Perez

Corresponding Filing Tracking Number:
FR2041GE

Filing Description:

Massachusetts Mutual Life Insurance Company

NAIC#: 435-65935

FEIN #: 04-1590850

Re: FR2041GE Application for Change of Policy
with LTCAccess Rider

SERFF Tracking Number: MASS-128229419 State: Arkansas
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FR2042GE Application for Reinstatement of Policy
With LTCAccess Rider

The above-captioned forms are being submitted for your review and approval. The forms are described below. The form is in final print format. Final print copies of the form and any required certifications are attached.

FR2041GE is an application used to change a life policy and its riders.
FR2042GE is an application to be used to reinstate a life policy and its riders.

These forms will be used with our Whole Life Policy, which was approved by your department on 1/3/12 under filing number MASS-127896260 and our Accelerated Death Benefit for Long Term Care Services Rider, which was approved by your department on 2/23/12 under filing number MASS-128093922.

Please direct all correspondence and questions regarding this filing to my attention. Thank you for your assistance.

Robin Perez
860-562-4409

State Narrative:

Company and Contact

Filing Contact Information

Robin Perez, Compliance Specialist rperetz@MassMutual.com
1295 State Street 860-562-4409 [Phone]
M177 860-562-6151 [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:
Springfield, MA 01111 FEIN Number: 04-1590850
(800) 767-1000 ext. [Phone]

Filing Fees

SERFF Tracking Number: MASS-128229419 State: Arkansas
Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number:
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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: 2012 Change and Reinstatement Apps
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Fee Required? Yes
Fee Amount: \$150.00
Retaliatory? Yes
Fee Explanation: \$75.00 x 2 forms
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Massachusetts Mutual Life Insurance Company	\$150.00	04/03/2012	57670974

SERFF Tracking Number: MASS-128229419 State: Arkansas
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Product Name: 2012 Change and Reinstatement Apps
Project Name/Number: 2012 Change and Reinstatement Apps/2012 Change and Reinstatement Apps

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/09/2012	04/09/2012

SERFF Tracking Number: MASS-128229419 State: Arkansas
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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: 2012 Change and Reinstatement Apps
Project Name/Number: 2012 Change and Reinstatement Apps/2012 Change and Reinstatement Apps

Disposition

Disposition Date: 04/09/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MASS-128229419 State: Arkansas
 Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number:
 Company Tracking Number: FR2041GE
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: 2012 Change and Reinstatement Apps
 Project Name/Number: 2012 Change and Reinstatement Apps/2012 Change and Reinstatement Apps

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	Application for Change of Policy with LTCAccess Rider		Yes
Form	Application for Reinstatement of Policy with LTCAccess Rider		Yes

SERFF Tracking Number: MASS-128229419 State: Arkansas
 Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number:
 Company Tracking Number: FR2041GE
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: 2012 Change and Reinstatement Apps
 Project Name/Number: 2012 Change and Reinstatement Apps/2012 Change and Reinstatement Apps

Form Schedule

Lead Form Number: FR2041GE

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	FR2041GE	Application/ Enrollment Form Application for Change of Policy with LTCAccess Rider	Initial		50.300	FR2041GE.pdf
	FR2042GE	Application/ Enrollment Form Application for Reinstatement of Policy with LTCAccess Rider	Initial		51.100	FR2042GE.pdf

Application for Reinstatement of Policy with LTCAccess Rider

For use only for a Life Policy with the Accelerated Death Benefit for Long Term Care Services Rider (LTCR)

To the Company as defined below:

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY
 1295 State Street, Springfield, Massachusetts 01111-0001
 www.massmutual.com

Claims for LTCAccess Rider accelerated benefits have been submitted and/or paid on this policy.

This application is used to reinstate a life policy and its riders, including the Accelerated Death Benefit for Long Term Care Services (LTCR), which is an individual rider on an individual policy. The application includes any Part 2 that may be required and any amendments and supplements.

This is an application to reinstate policy number _____

On the life of (insured) _____

Product Type _____

Please do not send any money with this application. If this application is approved, we will inform you of the amount due.

A. Personal Information **Complete this section for all cases**

► **Proposed Insured**

a. Date of Birth _____ b. Place of Birth _____

1. Full legal name (First, MI, Last, Suffix) _____

2. Sex: Male Female 3. US Social Security # / Tax ID # _____

4. Driver's License No. _____ State _____

5. Telephone Numbers: Home (_____) _____ Work (_____) _____

Best time to call _____ am pm at Home Work

6. Annual Income* Earned \$ _____ Unearned \$ _____

7. Financial Net Worth:* \$ _____

* If the proposed insured is not employed, please provide the Household Income \$ _____ and the Household Net Worth \$ _____

B. Insurability Information **Complete this section for all cases**

► **Proposed Insured**

1. Does the Proposed Insured currently need human assistance or supervision with bathing, maintaining continence, dressing, eating, transferring from bed to chair or toileting? Yes No

2. Has the Proposed Insured ever been medically diagnosed or treated by a member of the medical profession for any of the following:

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|----------------------------------|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS, HIV infections or AIDS related conditions | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's Disease | <input type="checkbox"/> | <input type="checkbox"/> | Muscular Dystrophy |
| <input type="checkbox"/> | <input type="checkbox"/> | Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) | <input type="checkbox"/> | <input type="checkbox"/> | Myasthenia Gravis |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | Organic Brain Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Cystic Fibrosis | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis |
| <input type="checkbox"/> | <input type="checkbox"/> | Dementia | <input type="checkbox"/> | <input type="checkbox"/> | Parkinson's Disease/Parkinsonism |
| <input type="checkbox"/> | <input type="checkbox"/> | Huntington's Chorea | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Insulin Dependent Diabetes (Type 1) | <input type="checkbox"/> | <input type="checkbox"/> | Transient Ischemic Attack (TIA) |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease requiring dialysis | <input type="checkbox"/> | <input type="checkbox"/> | Schizophrenia |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Cirrhosis | <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus |

3. Does the Proposed Insured currently use, or has the Proposed Insured used in the last 12 months, a wheelchair, walker, multi-prong cane, hospital bed, oxygen, motorized cart or stair lift? Yes No

4. Within the last 5 years, has the Proposed Insured had an application for Long Term Care insurance declined or rated? Yes No
5. Does the Proposed Insured currently need help, assistance or supervision in performing any of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation? Yes No
6. Within the last 10 years, has the Proposed Insured ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
- a. Amnesia? Yes No
 - b. Any Hip, Knee, Shoulder or other Bone or Joint Condition (such as Arthritis), Osteoporosis, Amputation due to disease or other medical condition? Yes No
 - c. Ataxia, Transverse Myelitis, Motor Neuron Disease or Post-Polio Syndrome? Yes No
 - d. A condition which causes limited motion? Yes No
7. Within the last 5 years, has the Proposed Insured been treated, examined or advised by a member of the medical profession regarding:
- a. Memory loss? Yes No
 - b. Tremors or numbness? Yes No
 - c. A fall, accident or imbalance which led to a neurological or physical injury? Yes No

8. List all medications prescribed and/or taken by the Proposed Insured in the last 24 months and provide the appropriate details as requested below.

Medication	Dose & Frequency	Prescribing Doctor	Reason for Taking	Date Started	Date Stopped

9. In the last ten years has the Proposed Insured received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol or prescribed or non prescribed drugs? Yes No
10. In the last ten years has the Proposed Insured used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician? Yes No
11. In the last two years has the Proposed Insured been treated, examined, or advised by a member of the medical profession to be admitted to a hospital or other medical facility? Yes No
12. Has the Proposed Insured ever tested positive for human immunodeficiency virus (HIV) or been treated or diagnosed by a member of the medical profession as having acquired immune deficiency syndrome (AIDS)? Yes No
13. Has the Proposed Insured been advised of, treated for, or had any known indications of cancer, stroke, heart disorder, respiratory disorder, blood disorder, tumor, kidney disorder, diabetes, high blood pressure, heart or circulatory disorder, or gastrointestinal disorder? Yes No

Details of "Yes" answers. *If you answered "yes" to any questions 8 through 13, please provide details below. Please reference the question number and include the condition, duration of condition, dates of treatment, results of treatment, tests performed, length of disability, degree of recovery and name and address of the medical professional or facility providing treatment who treated the condition. Attach additional sheets of paper, as needed, which will become a part of this application.*

Is there a current arrangement 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? Yes No

C. Personal History

Complete this section for all cases

► Proposed Insured

Have you

- 1. Smoked cigarettes in the past 12 months? Yes No
- 2. If "No," used tobacco or nicotine in any other form in the last 12 months? Yes No
- 3. Used tobacco or nicotine in any form during the past 24 months? Yes No

If you answered "Yes" to question 1 or 3, please provide details: _____

- 4. In the last 5 years 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
- 5. Ever been convicted of a felony? Yes No
- 6. Applied for life insurance within the last 10 years and been declined, postponed, rated, or restricted? Yes No
- 7. In the past 5 years has the Proposed Insured made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition? Yes No

Details of "Yes" answers. If you answered "yes" to any question 4 through 7, please provide details below. For question 7, reference the question number and include the condition duration, dates of treatment, results of treatment, name and address of the physician(s) who treated the condition. For questions 5 and 6, reference the question number and provide details. Attach additional sheets of paper as needed, which will become part of this application.

- 8. In the last 3 years been, or now expect to become, a pilot, student pilot, or crew member of any type of aircraft? ... Yes No
If "yes," what type of license(s) do you have? Private Commercial
- 9. In the last 3 years taken part in, or now expect to take part in, underwater diving, hang gliding, parasailing, parakiting, parachuting, skydiving, mountain climbing, or organized racing by automobile, motorcycle, motorboat, or snowmobile, or any other form(s) of hazardous activity? Yes No

If "yes," what type of activity do you engage in or expect to engage in? _____

- 10. Contemplate foreign travel? Yes No

**(Please note that a "Yes" answer could result in the policy being rated or declined.)
(If "Yes," complete a Foreign Travel and Residence Supplement.)**

If "yes," Location _____ Purpose _____
Duration _____ Dates _____

- 11. Does the Proposed Insured have life insurance coverage (individual or group) in force or an application currently pending? Yes No

If "yes," please provide the company name, year issued/pending, and the face amount:

► Proposed Insured

1. The Proposed Insured understands that he/she has the right to designate a person other than himself/herself to receive notice of lapse or termination of this Long Term Care insurance coverage for non-payment of premium. A lapse notice will be provided if we have not received your premium payment by the 30th day after it is due. A copy of the notice will be sent to the person designated below.

The Proposed Insured elects NOT to designate any person to receive such notice.

The Proposed Insured designates the following person to receive notice prior to cancellation of the policy for non-payment of premium:

a. Full Legal Name (First, MI, Last, Suffix): _____

b. Mailing address (Street, City, State, ZIP): _____

► Proposed Owner

Complete this section only if the Proposed Owner is other than the Proposed Insured

2. The Proposed Owner understands that he/she has the right to designate a person other than himself/herself to receive notice of lapse or termination of this Long Term Care insurance coverage for non-payment of premium. A lapse notice will be provided if we have not received your premium payment by the 30th day after it is due. A copy of the notice will be sent to the person designated below.

The Proposed Owner elects NOT to designate any person to receive such notice.

The Proposed Owner designates the following person to receive notice prior to cancellation of the policy for non-payment of premium:

a. Full Legal Name (First, MI, Last, Suffix): _____

b. Mailing address (Street, City, State, ZIP): _____

E. Agreement and Signatures

Each person signing below agrees that:

Definitions. The following terms used in this Application Supplement have the following meanings:

- “I”, “you”, and “your” mean the Proposed Insured;
- “We” and “our” mean the Proposed Insured and the Proposed Owner if other than the Proposed Insured;
- “Company” means Massachusetts Mutual Life Insurance Company; and
- “Policy” means the life insurance policy issued by the Company to which the LTCR is attached.

The Application – This is an application for reinstatement of life insurance and its riders, including the LTCAccess Rider. 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 Application for Reinstatement 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.

I understand that the Company may have different requirements and standards for evaluating my application for reinstatement of the life insurance policy and for evaluating my application for reinstatement of the LTC Access Rider. I understand that the Company may approve reinstatement of the life insurance policy but not approve reinstatement of the LTC Access Rider.

No coverage will be in force until (1) we approve this Application for Reinstatement and any required evidence of insurability satisfactory to the Company, (2) the cost to reinstate, as applicable, and all premium and any interest as may be required under the policy to reinstate coverage have been paid, and (3) all other conditions as required under the policy to reinstate coverage have been met.

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 payment of any cost to reinstate.

Notice of Insurance Information Practices. To evaluate your Application for Reinstatement, the Company will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information is obtained about you. You also have the right to request correction of any erroneous information. The information obtained about you will be used by the Company to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. The information obtained may not be released to any person or organization except to reinsuring companies, any third party administrators designated by the Company or other persons or organizations performing services in connection with your application, claim or as may be otherwise lawfully required or as you may further authorize. The Company will furnish a more detailed summary of our information practices upon request.

Federal Tax Information. THE BENEFITS PROVIDED BY THE LTCR ARE INTENDED TO BE EXCLUDABLE FROM FEDERAL GROSS INCOME UNDER SECTION 101(g) OF THE INTERNAL REVENUE CODE, as amended (the “Code”). Under current tax laws, benefits provided by the LTCR may be taxable if the Proposed Owner is not either the Proposed Insured or the Proposed Insured’s spouse. The LTCR will be endorsed to conform to changes in the law. The LTCR is not intended to be federally tax-qualified long term care insurance contract under Code Section 7702B. The Proposed Insured and the Proposed Owner, if different, should consult with his or her attorney, accountant or tax advisor regarding the tax implications of purchasing the LTCR.

I/We have read the answers given in this Application for Reinstatement and they are complete and true to the best of my/our knowledge and belief. I/We understand that the Company will rely on my/our written answers to the questions in this Application for Reinstatement, and that if my/our answers are not complete and true, my/our policy and any riders, including the LTCR, may not be valid. I/We also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy.

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.

CAUTION: If your answers on this Application for Reinstatement are incorrect or untrue, the Company may have the right to deny benefits, or rescind the Policy and any riders, including the LTCR.

Each person signing below is aware and agrees that coverage is not in force until this application is approved by the Company, any forms needed are properly completed, and the required payment is received.

Signed at _____ on _____
City and State Date

Owner's Name (print or type) Owner's Signature Date

Proposed Insured's Name (print or type) Proposed Insured's Signature Date

Name of Corporation, Partnership, or Trust (print or type)

Signature & Title Date Signature & Title Date

Signature & Title Date Signature & Title Date

Return this completed form to:

MassMutual Financial Group
Enterprise Document Management Services
1295 State Street
Springfield MA 01111-0001.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: Generic Readability Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: The applications have been placed under the Forms Schedule tab.		

READABILITY CERTIFICATION

Massachusetts Mutual Life Insurance Company

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>
FR2041GE	Application for Change of Policy with LTCAccess Rider	50.3
FR2042GE	Application for Reinstatement of Policy with LTCAccess Rider	51.1

Signature:

Jo-Anne Rankin

Jo-Anne Rankin
Vice President

Digitally signed by Jo-Anne Rankin
DN: cn=Jo-Anne Rankin, c=US,
o=MassMutual Financial Group,
email=jrankin@massmutual.com
Reason: I agree to the terms defined by the
placement of my signature on this document
Date: 2012.04.03 09:11:37 -04'00'