



		(Last, First, Middle Initial)
Telephone #	Address	

**PROPOSED INSURED(S)**

Name	Relationship	Date of Birth	Height	Weight (if pregnant, pre-pregnancy weight)

**REASON**

NEW

- Late Applicant
- Applying for Coverage in Excess of the Guaranteed Amount
- Applying for Supplemental Coverage
- Other \_\_\_\_\_

CHANGE

- Increase in Coverage
- Adding Spouse
- Increasing Spouse
- Adding Dependent Child(ren)
- Other \_\_\_\_\_

**INSURANCE**

<u>YOU</u>	<u>LIFE</u>	<u>AD&amp;D</u>	<u>VOLUNTARY LIFE</u>	<u>VOLUNTARY</u>	<u>AD&amp;D</u>
Current Insurance	_____	_____	_____	_____	_____
Additional Insurance Requested	_____	_____	_____	_____	_____
Total New Coverage	_____	_____	_____	_____	_____
<input type="checkbox"/> Short Term Disability	\$ _____				
<input type="checkbox"/> Long Term Disability	\$ _____		<input type="checkbox"/> Other	\$ _____	
	Weekly Benefit				
	Monthly Benefit				
 <u>YOUR SPOUSE</u>	 <u>LIFE</u>	 <u>AD&amp;D</u>	 <u>VOLUNTARY LIFE</u>	 <u>VOLUNTARY</u>	 <u>AD&amp;D</u>
Current Insurance	_____	_____	_____	_____	_____
Additional Insurance Requested	_____	_____	_____	_____	_____
Total New Coverage	_____	_____	_____	_____	_____
			Other	<input type="checkbox"/>	\$ _____

EVIDENCE OF INSURABILITY

			Do you intend to replace or change this coverage if you and your dependents are approved for the insurance applied for on this application?


\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY**  
*(This authorization complies with the HIPAA Privacy Rule)*

\_\_\_\_\_  
Name of (Proposed) Insured/Patient (please print)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name of Second (Proposed)

This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, 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.**

By my signature below, I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

**This protected health information is to be disclosed under this Authorization so that BML may:** 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

**This authorization shall remain in force for 24 months** following the date of my signature below, and a copy of this authorization is as valid as the original. **I understand that I have the right to revoke this authorization in writing**, at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

\_\_\_\_\_  
Signature of Proposed Insured/Claimant/Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient

\_\_\_\_\_  
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.

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date