Life Insurance Application Package

Life New Business Application Package for LifeBridge℠ Policies

Life 1

THIS PACKAGE MAY BE USED FOR:	LifeBridge Business
USE THIS PACKAGE IN THE FOLLOWING CONTRACT STATE:	Connecticut
THIS PACKAGE INCLUDES:	• LifeBridge℠ Beneficiary Enrollment Form (MassMutual Trust Co.) (F7013) • Application Part 1 (A70CT) • Application Part 2 (A50CT) • Producer's Statement (A1AGE) • State Disclosure Authorization (A1894-8900) • HIPAA Authorization/Personal Health-Related Information (F8186) • HIV Consent (N201CT) • Important Privacy and Consumer Information (N2000) • Notice of Information Practices (N170)

IMPORTANT REMINDERS:

The following are guidelines for completing this package:

- Refer to the Life Annotated Application Part 1 (LB1002) for assistance in completing the Application Part 1.
- Complete ALL required sections and obtain all signatures and titles (where required).
- Do not use pencil to complete application or "white out" to make changes. If a change is made to an answer, the owner must initial the change.
- Application Part 2 is required for all LifeBridge applications (included).
- Order blood and urine samples.
- Complete and sign the Producer's Statement.
- Provide client with all required notices.

Checklist for using the LifeBridge Application:

- Eligibility Form is attached or submitted.
- Applicant is between the ages of 19 and 42.
- A tax return or W-2 form and/or a current pay stub showing total family income between $10,000 and $40,000.
- Producer's Statement has been signed.
- A completed Foreign Travel Supplement (F6290) is attached if the applicant is not a US citizen or anticipates foreign travel. If the applicant is not a US citizen, a photocopy of their permanent visa is also required.
- A Completed resident state HIV Consent Form and the CT state HIV Consent Form (N201CT) are both attached if the applicant is from a state that requires its own HIV Consent Form. The CT state HIV Consent Form is always required.
- Attach lab slip if blood and urine samples were completed at the time of application.

MassMutual

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

MassMutual

LifeBridge℠ Beneficiary Enrollment Form

For MassMutual Trust Company Use Only
☐ Initial
☐ Amended

The MassMutual Trust Company, FSB, as Trustee of the LifeBridge Trusts, will apply to purchase a 10-year term life insurance policy issued by MassMutual insuring your life. If the policy is approved and issued, the LifeBridge Trust will be named as the sole beneficiary of the policy. If you die during the term of the policy, the Trustee will collect any death benefits under the policy and make distributions for certain expenses incurred by the beneficiaries (listed below) for their education. Eligible expenses* include tuition, related fees, books, room and board, including amounts owed under outstanding student loans, including interest. Any payment shall be made directly to the provider of such services. In no event will payment be made directly to the Beneficiary.

* Additional information, including specific eligible education expenses and terms of the LifeBridge program, can be found in the LifeBridge Brochure *[and a copy of a LifeBridge Trust].*

Identify Your Eligible Children - Please name one or more individuals to receive equal benefits under the Trust. You must be the parent or legal guardian of these individuals. YOU CAN ADD INDIVIDUALS TO THE LIST BELOW ONLY BY COMPLETING AN AMENDED ENROLLMENT FORM, and you have no other right, title or interest in the LifeBridge Trust. Please write in (print) the beneficiaries you wish to name under the LifeBridge program:

Name	Address (if different than your own)	Social Security Number	Date of Birth

Identify a Charity - In some cases, the full amount of the benefits from the policy may not be paid out as described above. (For example, education expenses are less than the amount of the benefit.) In such event, the Trustee will pay any remaining funds to a charity. Select from the following list, the charitable entity to receive the balance of any such proceeds: (if no charities are checked, all five of the charities listed below will receive an equal share)

☐ Hispanic Scholarship Fund ☐ United Negro College Fund ☐ The National Urban League, Inc: *National Achievers Society Scholars Fund*

☐ Community Foundation of Western Massachusetts ☐ The Achievement Foundation Inc. (Joe Francomano Scholarship)

Your Address and Signature

Your Name _____

Address _____
Street

_____
City State Zip

Phone (_____)_____ (optional) **E-mail Address** _____ (optional)
Area Code Telephone

Signature

X _____ _____
Signature of Proposed Insured Date

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

MassMutual

Application Part 1 - Individual Term Life Insurance

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY
(MassMutual) 1295 State Street, Springfield, Massachusetts 01111-0001

A Proposed Insured — COMPLETE THIS SECTION FOR ALL CASES

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 #/TIN _____ - - _____

5a. US Driver's License # _____

State _____

Expiration Date _____ / / _____

5b. If none, type of government-issued photo ID

_____

Country/State of issue _____

ID # _____

Expiration Date _____ / / _____

6a. Citizenship:
☐ US Citizen, Resident ☐ US Citizen, Non-Resident
☐ Alien, Resident ☐ Alien, Non-Resident

6b. Non-US Citizens provide:
Type of Visa _____
Country of Citizenship _____

7. Telephone #'s Home ( ) -
Work ( ) - Cell ( ) -

8. Email address _____

9. Residential Address

_____

_____

_____

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

10. Is Proposed Insured sole owner? ☐ Yes ☑ No
(Upon death to his/her estate)

11. Collateral Assignment ☐ Yes ☑ No
(If "Yes", complete Collateral Assignment Form F5308)

B Term Life Policy Information — COMPLETE THIS SECTION FOR ALL CASES

1. Product ET10 (ECTL)
2. Face Amount $ 50,000
3. Dividend Option: ☐ Dividend Accumulation (DA) ☐ Cash (CS) ☐ Reduced Premium (RP)
4. ☐ Waiver of Premium Rider (WP)
5. Details _____

C Premium Payment Information — COMPLETE THIS SECTION FOR ALL CASES

1. Frequency: ☐ Monthly (PAC or Group Only) ☐ Quarterly ☐ Semi-annual ☑ Annual
2. Billing Type:
☐ Pre-Authorized Check (PAC) ☐ Individual Direct Bill
☑ Group Bill (provide Inv. Fran. #) 159357
3. Specify Policy Date (if other than Issue Date) / /
4. Date policy to save age for the Proposed Insured ☐ Yes ☐ No
5. Has the initial premium been paid? ☐ Yes ☑ No
(If "Yes", complete Temporary Life Insurance Receipt)
6. Source of Premium (check all that apply):
☐ Earned Income ☐ Investment Income
☐ Investment/Savings ☐ Gifts/Inheritance
☐ Loan **(Complete Premium Financing Supplement F7002)**
☐ Other (specify) _____

7. Premium Payor:
☐ Proposed Insured ☐ Proposed Owner
☑ Other (provide name and mailing address below)

Full Legal Name MassMutual Trust Company
(First Name or Entity Name) (Middle Initial)

(Last Name) (Suffix)

Mailing Address
100 Bright Meadow Boulevard
Enfield, CT 06082

_____

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

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

1a. Personal Needs:
- ☐ Income for Dependents
- ☐ Estate Taxes
- ☐ Mortgage Cancellation
- ☑ **Education Fund**

1b. Business Needs:
- ☐ Key Employee
- ☐ Stock Redemption
- ☐ Cross Purchase
- ☐ _____

1c. Is this policy being purchased in connection with an employer-sponsored plan?
- ☐ Yes If "Yes", check one of the following:
  - ☐ Tax-qualified employer-sponsored plan
  - ☐ Non-qualified employer-sponsored plan
- ☑ 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?	☐	☑
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)	☐	☑
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)	☐	☑
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)	☐	☑

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).
$ **50,000**

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)**

F Proposed Owner Information — COMPLETE THIS SECTION ONLY IF OWNER IS OTHER THAN PROPOSED INSURED

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)
LifeBridge Free Life Ins. Program Trust Agreement, MassMutual Trust Company, Trustee

13. Tax ID #/SSN **56-6610867**

14. Situs of Trust ____

15. Citizenship: ☐ US Entity ☐ Alien Entity

16. Email address ____

17. Legal Address

100 Bright Meadow Boulevard

Enfield **CT** **06082**

(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 Trust %

Name (If Trust, provide full name of Trust) LifeBridge Free Life Ins. Program Trust Agreement, MassMutual Trust Company, Trust

Relationship to Insured _____ DOB/Date of Trust 04/01/2003 ☐ 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), _____ (name of adult to act as Custodian) shall be said Custodian for said child(ren) under the _____ (state) Uniform Transfers/Gifts to Minors Act.

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 $ N/A **7c.** Net Worth $ N/A

8. Occupation _____ Duties _____

Employer Name & Address _____

_____

_____

_____

_____

9a. If Proposed Insured is not employed: Household Income $ N/A **9b.** Household Net Worth $ N/A

I Agreements and Signatures — COMPLETE THIS SECTION FOR ALL CASES

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 STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

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) **Enfield, CT** (City and State where Proposed Owner signed)

Signature of Proposed Insured	Signature of Soliciting Producer
X _____ Proposed Insured	X _____ Soliciting Producer Agency #
Signature of Proposed Owner - If Other than Proposed Insured	**Signature of Proposed Joint Owner - If Applicable**
X **MassMutual Trust Company** Proposed Owner Include Title (if applicable)	X _____ Proposed Owner Include Title (if applicable)

MassMutual

Application for Life or Disability Income Insurance (Part 2)

To the Company as defined below:

☐ **Massachusetts Mutual Life Insurance Company (MassMutual)** 1295 State Street, Springfield, Massachusetts 01111-0001

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

☐ **C.M. Life Insurance Company** 100 Bright Meadow Boulevard, Enfield, Connecticut 06082

Use this Application to provide additional information on the Proposed Insured. Complete all sections for all cases.

A Personal Information

1. Proposed Insured full legal name *(First, MI, Last, Suffix):* _____

2. Date of birth (*mm/dd/yyyy):* ____/____/____

3. Social Security Number or Taxpayer Identification Number: _____

4. Current height *(Feet and Inches):* _____ Current weight *(Pounds):* _____

5. If your weight changed by over 10 pounds in the last year, indicate amount and reason: _____

_____

6. Current primary physician name *(First, MI, Last, Suffix):* _____

a. Physician business address *(Street, Suite #, City & State or Country, ZIP/Postal Code):*

_____

_____

b. Physician Phone Number: (_____) _____ -- _____

c. Date last seen by physician and reason: _____

_____

7. Family History. *Include immediate family (parents and siblings). Use Details section for additional space.*

Relative	Health Problems – Include Age of Onset	Age if Living	Age at Death	Cause of Death
Father				
Mother				
Brother(s)/Sister(s)				

B Personal History Information

If Proposed Insured answers Yes to any question, provide additional information in Supplement A.

1. Has the Proposed Insured used tobacco or other nicotine containing products *(e.g. cigarettes, pipes, cigars, snuff, chewing tobacco or nicotine delivery device such as gum or the patch):*

a. Within the last 12 months? ☐ Yes ☐ No

b. Within the last 24 months? ☐ Yes ☐ No

2. Is the Proposed Insured currently:

a. Under treatment or taking any prescription medications (other than contraceptives)? ☐ Yes ☐ No

b. Taking any herbal or non-prescription medication at least weekly? ☐ Yes ☐ No

c. Pregnant? ☐ Yes ☐ No

If Yes, expected delivery date: _____

B Personal History Information *continued*

3. To the best of the Proposed Insured's knowledge and belief, has the Proposed Insured ever had, been told or ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions? ☐ Yes ☐ No

4. In the past 10 years, has the Proposed Insured 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. Chest pain, heart attack, high blood pressure, heart murmur, palpitations or any other disorder of the heart, arteries or veins? ☐ Yes ☐ No

b. A tumor or cancer including skin cancer, melanoma or colon polyps? ☐ Yes ☐ No

c. A disorder of the blood, spleen, immune system (excluding AIDS or HIV) including anemia, blood clots, bleeding, immune deficiency, leukemia or lymphoma? ☐ Yes ☐ No

d. A disorder of the brain, spinal cord or nervous system including seizures, tremors, paralysis, dizziness, fainting, headaches, stroke or TIA (transient ischemic attack)? ☐ Yes ☐ No

e. Depression, anxiety, nervousness, stress, psychosis, suicide thoughts or attempts, anorexia or bulimia, post traumatic stress disorder, obsessive compulsive disorder, bipolar disorder, attention deficit hyperactivity disorder (ADHD) or other emotional disorder? ☐ Yes ☐ No

f. A disorder of the eyes, ears, nose, throat or sinuses including any partial or complete loss of hearing, vision or speech? ☐ Yes ☐ No

g. Asthma, allergies, shortness of breath, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), pneumonia, sleep apnea, tuberculosis or any other disorder of the respiratory system? ☐ Yes ☐ No

h. A disorder of the digestive system, liver, pancreas or gall bladder including hepatitis, jaundice, ulcers, intestinal bleeding, colitis, Crohn's disease (ileitis), recurrent indigestion, diarrhea or diverticulitis? ☐ Yes ☐ No

i. A disorder or impairment of the muscles, bones, joints, nerves, spine, neck or back including arthritis, gout, sciatica or amputations? ☐ Yes ☐ No

j. Epstein-Barr virus, Lyme disease, chronic fatigue syndrome, fibromyalgia, lupus or other rheumatologic disorder? ☐ Yes ☐ No

k. Diabetes or a disorder of the thyroid, pituitary or adrenal glands? ☐ Yes ☐ No

l. A disorder of the kidneys, bladder, prostate or urinary tract or findings of sugar, protein or blood in the urine? ☐ Yes ☐ No

m. A disorder of the skin including eczema or psoriasis? ☐ Yes ☐ No

n. A disorder of the uterus, cervix, ovaries or breasts? ☐ Yes ☐ No

o. Multiple miscarriages, complicated pregnancy or infertility evaluation? ☐ Yes ☐ No

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

a. Used cocaine, barbiturates, amphetamines, heroin, narcotics, stimulants, hallucinogens or other controlled substances or habit forming drugs not prescribed by a physician? ☐ Yes ☐ No

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? ☐ Yes ☐ No

6. In the last 5 years, has the Proposed Insured:

a. Had an application for life, disability or health insurance declined, postponed, rated or restricted? ☐ Yes ☐ No

b. Had a sickness or injury for which a disability claim was made or payments, benefits or pension benefits were received? ☐ Yes ☐ No

7. In the last 3 years, unless previously stated on the application, has the Proposed Insured:

a. Had a physical exam, check-up or evaluation by a health professional? ☐ Yes ☐ No

b. Had an injury treated by a health professional or medical facility? ☐ Yes ☐ No

c. Had an electrocardiogram, x-ray, blood test or other diagnostic test, excluding an HIV test? ☐ Yes ☐ No

d. Had surgery or been a patient in a hospital, clinic or other medical or mental health facility? ☐ Yes ☐ No

e. Been advised to have surgery, medical treatment or diagnostic testing, excluding HIV testing that has not been completed? ☐ Yes ☐ No

C Additional Information

Details. *Provide additional details for questions answered Yes. Use Supplement 'A' for additional space.*

Question	Details and Medications	Name of Physician	Address of Physician

D Agreements & Signatures

I, the undersigned, 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 MassMutual and no information about me will be considered to have been given to MassMutual unless it is stated in the application. I hereby adopt all statements made in the application and agree to be bound by them.

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.

Signed at *(City & State):* _____ Date: _____

▶ Signature of Proposed Insured: _____

Printed Name: _____ Date: _____

▶ Signature of Witness: _____

Printed Name: _____ Date: _____

MassMutual

Supplement "A" to Application Part 2

Use this supplement to provide additional information for questions answered Yes.

A Personal Information

1. Proposed Insured full legal name *(First, MI, Last, Suffix):* _____
2. Date of birth *(mm/dd/yyyy):* _____
3. Social Security Number or Taxpayer Identification Number: _____

B Additional Information

.

Question	Details and Medications	Name of Physician	Address of Physician

Signature of Proposed Insured: _____

Printed Name: _____ Date: _____

Signature of Witness: _____

Printed Name: _____ Date: _____

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

MassMutual

Producer's Statement

Use this form for all Life New Business applications and MassMutual Income Protection Option (MMIPO) Program. This form must be completed and signed by the Soliciting Producer.

A Life Policy Information

1. Risk classification presented to:

a. Insured 1: N/A

b. Insured 2 *(If applicable):* N/A

2. Is this part of a multi-policy case (i.e. family members, business partners, etc.)? ☐ Yes ☑ No

If Yes, provide associated policy number(s): _____

3. Are there any other applications (e.g. Disability, Long Term Care) being submitted concurrently with this Application or within the last two months? ☐ Yes ☑ No

If Yes, provide associated policy number(s): _____

4. Is the policy being applied for a replacement? ***If Yes, complete applicable replacement forms.*** ☐ Yes ☑ No

5. Will dividends from an existing MassMutual policy be used to pay all or part of the initial premium on this policy? ***If Yes, complete Service Request Form (F5341).*** ☐ Yes ☑ No

6. 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): _____

7. Are you aware of whether the Proposed Owner or Proposed Insured has arranged, or discussed arranging, any financing for the purchase of this policy? ***If Yes, complete applicable Premium Financing Supplement (F7002).*** ☐ Yes ☑ No

8. 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

9. Are you aware of any person signing this Application who did **not** understand and answer each question in English? ***If Yes, complete applicable Acknowledgment Regarding English Language Materials and Translation (FR1119).*** ☐ Yes ☑ No

If Yes, indicate language: _____

10. Market type *(Select all that apply):*

- ☐ N/A
- ☐ Business Owner
- ☐ Existing Customer
- ☐ Family Markets
- ☐ Lesbian, Gay, Bisexual & Transgender (LGBT) Markets
- ☐ Multicultural Markets
- ☐ SpecialCare – Families with special needs*
- ☐ Women's Markets
- ☑ Other *(Specify):* LifeBridge

**Note: The receipt of insurance benefits by a beneficiary or dependent with special needs could negatively affect that individual's eligibility for government benefits.*

Complete question 11 for Variable products only, otherwise skip to question 12.

11. Did you deliver a current copy of the Prospectus and any applicable supplements? ☐ Yes ☐ No

If Yes, provide Prospectus Effective Date *(from front cover of Prospectus; mm/dd/yyyy):* _____

Individual Disability Income Insurance through MassMutual Income Protection Option *(Complete only if also applying for MMIPO)*

Producer commissions will be split as indicated in section B as long as they are licensed. Agency splits are not allowed.

12. Individual business discount *(Select, if applicable):* ☐ Spousal

13. To the best of your knowledge, will the insurance being applied for replace any existing disability income insurance with this or any other company? ***If Yes, complete the applicable replacement form as required in all states for MMIPO.*** ☐ Yes ☐ No

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

B Producer Compensation Information

Complete the first line for all applications and provide additional compensation arrangements if applicable.

	Producer Type	Producer ID #	Printed Name	Agency #/ Distributor ID	Entity Name/Entity #	% 1st Year Commission	% Renewal Commission
1	**Soliciting**						
2							
3							
4							
5							
6							
7							
8							
						Total: 100%	**Total: 100%**

C Contact Information

Agency Contact *(To be used when the Underwriter/Case Manager has questions or needs additional information about this case)*

1. Contact name: _____

2. Phone number: (_____) _____ - _____ Extension: _____ ☐ Home ☐ Work ☐ Mobile

3. Email address: _____

Additional Agency Contact *(If applicable)*

4. Contact name: _____

5. Phone number: (_____) _____ - _____ Extension: _____ ☐ Home ☐ Work ☐ Mobile

6. Email address: _____

D Agreements & Signatures

I certify to the best of my knowledge, information and belief that:

- The statements made in this Producer's Statement are true and accurate.
- Each question in the Application was asked of the Proposed Insured(s) and Proposed Owner(s) and accurately recorded.
- All required forms and notices were provided to the Proposed Owner (and Proposed Insured, if different) prior to completing the Application.
- 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.
- The policy applied for is consistent with the financial needs of the Proposed Insured(s) and/or Owner(s).
- I am unaware of any information that would adversely affect any of the Proposed Insured's eligibility, acceptability or insurability.
- If this is an Application for Life Insurance with Long Term Care Access Rider, all of my applicable state life and health licenses were in place, and I completed all applicable MassMutual and state long-term care pre-sale and ongoing training requirements prior to solicitation.

Signature of Soliciting Producer: _____

Printed name: _____ Date: _____

Producer ID #: _____

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY and Affiliated Insurance Companies

DISCLOSURE AUTHORIZATION

Permission To Obtain Information
I hereby authorize any licensed physician, medical practitioner, clinic, hospital or other medical or medically related facility, insurance company, the Medical Information Bureau, consumer reporting agency, or other organization that has any records or knowledge of me or my health, to make such information available to the Massachusetts Mutual Life Insurance Company or its Affiliated Insurance Companies (hereinafter referred to as the Company) or their reinsurers.

If insurance on any minor child is applied for, this authorization extends to records or knowledge of that child or that child's health.

Types of Information Requested
The information requested by the Company may include all information available regarding any diagnosis, treatment and prognosis with respect to any physical or mental condition, and any non-medical information of me or my minor child.

Drug and / or Alcohol Abuse Treatment
I specifically give permission for the Company to obtain information relating to drug and/or alcohol abuse treatment for the purposes described in this authorization. I also understand that I may revoke this authorization in writing as it applied to drug and/or alcohol abuse information at any time, but my revocation will not affect any information that has been released under this authorization.

Use and Disclosure
This information collected will be used for determining eligibility for insurance with the Company, for reinsurance with the Company's reinsurers, and for other insurance purposes such as reinstatement or request for change in benefits. The agent may retain copies of your application papers.

All or part of the information obtained may be sent to other insurance companies who hold valid authorizations signed by you or to the Company's reinsurers in connection with claims or insurance underwriting. It may also be given to the Medical Information Bureau which operates an information exchange for member companies.

If an investigative consumer report is required, and you wish to be personally interviewed, please let us know and we will notify the consumer reporting agency.

Copy of Authorization / Notice
I understand that I may receive a copy of this authorization upon request. I agree that a photocopy of this authorization may be used to obtain information. I have been given a copy of the Company's Notice on the Medical Information Bureau and the Fair Credit Reporting Act, and the Notice of Information Practices.

THIS AUTHORIZATION IS VALID FOR 30 MONTHS AFTER THE DATE OF SIGNING.

Witness	Proposed Insured (or Annuitant)	Date
Witness	Applicant (if application is for Juvenile Insurance) or Waiver of Premiums Rider on Applicant)	Date
Witness	Proposed Insured 2 (or 2nd Annuitant)	Date

Name(s) of minor child(ren) _____

A1894 8900

MassMutual

HIPAA Authorization

For use with Life, DI & Life with Long Term Care Riders

This Authorization complies with HIPAA Privacy Rule. "HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended. "I", "you" and "your" refer to the Proposed Insured or Insured.

A Authorizations

- I hereby authorize the use and disclosure of my medical records, medical history and other information that relates to the diagnosis, treatment or prognosis of any physical or mental condition, whether in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs and pharmaceutical records; diagnostic testing; laboratory records; alcohol or drug use; and communicable or infectious diseases or conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases unless otherwise restricted by state law.
- This Authorization specifically excludes psychotherapy notes. Psychotherapy notes means notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session, and that are separated from the rest of any individual's medical record. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop dates, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date; therefore, such medical records are covered by this Authorization.
- I hereby authorize the following persons or entities who have provided payment, treatment or services to me or on my behalf within the past ten (10) years to disclose all medical or health information about me: a physician; medical practitioner or health care professional or provider; hospital; clinic; laboratory; medical or medically-related facility; pharmacy or pharmacy benefit manager; health plan. I further authorize the following persons or entities to disclose all medical or health information about me: any insurance company, including the Company ("Company" as referred to herein, is Massachusetts Mutual Life Insurance Company, and/or MML Bay State Life Insurance Company and/or C.M. Life Insurance Company), or reinsurance company; any consumer reporting agency such as the MIB, Inc. ("MIB"); the Department of Motor Vehicles or any other state or federal government agency; and/or any other organization, institution or person having personal health information about me.
- I hereby authorize the disclosure of my medical or health information to the Company, its service providers, its reinsurers and its agents, representatives and insurance producers (including the agents, representatives and employees of such persons or entities). I hereby authorize the disclosure of my medical or health information to any consumer reporting agency, including the MIB.
- I hereby authorize the use and disclosure of my medical or health information for purposes of and in connection with underwriting my application for insurance with the Company, determining the premium for the insurance, obtaining reinsurance, servicing my insurance and administering coverage, evaluating any claim for insurance benefits and conducting other legally permissible activities that relate to any coverage I have applied for. I understand that there may be additional uses or disclosures of my medical or health information that are specifically permitted by law without my Authorization, such as to government regulatory or law enforcement entities.

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

B Agreements & Signatures

If I do not sign this Authorization, the Company may (i) decline my application for insurance or not be able to offer me any coverage and/or (ii) decline to pay a claim for benefits under any insurance issued. Providers of health care services or medical treatment may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.

My Authorization may be revoked by sending a written request to:

MassMutual
Attn: Authorization Administrator – Underwriting Dept.
1295 State Street
Springfield, MA 01111-0001

I may not revoke any Authorization that was obtained as a condition of obtaining insurance, paying a claim, or that was relied or acted upon.

This Authorization applies to my entire medical record. Any agreements I have made to restrict my medical or health information do not apply to this Authorization.

My health information may be re-disclosed and no longer protected by HIPAA if the person receiving this information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers providing long-term care insurance and health care providers. However, the Company requires its employees, agents, representatives, insurance producers and service providers to protect the confidentiality of health information regardless of whether the employee, agent, representative, insurance producer or service provider is engaged in an insurance business subject to HIPAA. Information may only be re-disclosed in accordance with applicable laws or regulations.

This Authorization shall be valid for twenty-four (24) months from the date I sign it. A copy or facsimile of this Authorization may be relied upon as if it were an original.

I, or the Representative authorized to act on my behalf, have received a copy of this Authorization.

Some states' rules concerning Authorizations change the terms and provisions of this Authorization. By signing below, you acknowledge the conditions identified on page three are considered part of this Authorization and apply in the identified states.

Signature *(Required for all cases)*

Signature of Proposed Insured/Insured/Representative: _____

Printed name: _____ Date: _____

Proposed Insured/Insured's full legal name *(If different than above):* _____

Proposed Insured/Insured's date of birth *(mm/dd/yyyy):* _____

Relationship to Proposed Insured/Insured *(If Representative):* _____

C State-Specific Authorizations

If you reside in a state listed below, then the identified provisions apply to your Authorization.

- **ARIZONA.** With respect to disclosure of HIV-related information only, this Authorization is valid for 180 days from the date it is signed.
- **MAINE.** This Authorization excludes the disclosure of the result of a test for HIV if the Proposed Insured or Insured has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat shall otherwise prohibit this Authorization from including other facts and information relative to the fact that the Proposed Insured or Insured has AIDS.
- **MINNESOTA.** This Authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency personnel who were tested as a result of performing emergency medical services. The term **"emergency medical personnel"** includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.
- **NEW MEXICO.** "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant, proposed insured or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant, proposed insured or insured is known to have a direct, close personal, family or abuse-related counseling relationship. During the time this Authorization is valid it extends to the information required to determine eligibility for benefits under any policy issued as a result of this application.

  With respect to confidential abuse information, this Authorization may be revoked in writing, ten days after receipt by the Company, but doing so may result in an application or claim being denied or may otherwise adversely affect a pending insurance action.

  The Company may collect genetic information about you for use in conducting and administering its business of insurance. "Genetic information" means the information about a genetic makeup of a person or members of a person's family, including information resulting from genetic testing, genetic analysis, DNA composition, participation in genetic research or use of genetic services. This information may only be used, transmitted or retained for the purpose of conducting and administering its business of insurance, except with your consent or as otherwise authorized or required by law.
- **OREGON.** With respect to disclosure of HIV-related information only, this Authorization is valid for 180 days from the date it is signed.
- **VERMONT.** This Authorization does not extend to previously administered test for HIV antibodies, T-Cell counts, AIDS or ARC, nor to any medical doctor, doctor of osteopathy, physician, health care professional, hospital, clinic, medical facility, the Veterans Administration, the MIB Inc., employer, consumer reporting agencies, other insurance company, or anyone else, with respect to previous test results. I am not providing authorization for the release of results from any new test for the HIV virus to any outside, non-affiliated company nor to any company not under contract with the company to perform underwriting services.
- **VIRGINIA.** If this Authorization is used for claim purposes it is valid for the duration of the claim.

MassMutual

Notice and Consent Form for AIDS Virus (HIV) Antibody/Antigen Testing (Connecticut)

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid, and/or urine for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV antibodies or antigens. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Should you desire more information about the test of HIV infection before providing a blood, oral fluid and/or urine sample, you may wish to consult with your physician or your local health department. If you are at high risk of HIV infection, you may want to be counseled and tested by your physician or at a free/low cost local test site. Your local health department can provide you with information as to the location of these sites.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors, but not to agents or brokers.

If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific laboratory test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc.

The organizations described in the last two paragraphs may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant laboratory abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

You are urged, at this time, to designate the physician or other health care provider to whom the HIV test results may be disclosed by the Insurer in the event the results are other than normal.

I authorize the disclosure of any HIV test results which are other than normal to the following physician or health care provider.

Physician _____ Address _____

_____

_____

I have read and understand this Notice of Consent for AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the collection of blood, oral fluid and/or urine from me, the testing of that blood, oral fluid and/or urine, and the disclosure of the results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be valid as the original.

_____ _____

Proposed Insured Date of Birth

X _____ _____ _____

Signature of Proposed Insured or Parent/Guardian | Date | State of Residence

MassMutual

Important Privacy & Consumer Information

At Massachusetts Mutual Life Insurance Company ("MassMutual"), we recognize that our relationships with you are based on integrity and trust. As part of that trust relationship, we want you to understand that in order to provide our products and services to you, we must collect, use and share personal information about you. This Privacy Notice describes policies and practices about how we protect, collect and share personal information related to the products and services you receive from us, including life insurance, disability income insurance, long-term care insurance, and individual annuities. It also describes how you can limit some of that sharing.

Disclosures

Privacy Notice

We protect your personal information by:

- Using security measures that include physical, electronic and procedural safeguards to protect your personal information from unauthorized access or use in accordance with state and federal requirements.
- Training employees to safeguard personal information and restricting access to personal information to those employees who need it to perform their job functions.
- Contractually requiring business partners with whom we share your personal information to safeguard it and use it exclusively for the purpose for which it was shared.

Personal information we may collect. The types of personal information we may collect depend on the type of product or service you have with us and may include:

- Information that you provide to us on applications or forms, during conversations with us or our representatives, or when you visit our website (for example, your name, address, Social Security number, date of birth, income, and assets, beneficiaries, and medical or health information).
- Information about your transactions with us and our affiliates, including your policy coverages, premiums, and payment history.
- Information from third parties such as consumer or other reporting agencies and medical or health care providers.

We may share all of the personal information we collect, as described above, with:

- Agents, brokers and others who provide our products and services to you;
- Our affiliated companies, such as insurance or investment companies, insurance agencies or broker-dealers that market our products and services to you;
- Companies that perform marketing or administrative services for us;
- Nonaffiliated companies in order to perform standard business functions on our behalf including those related to processing transactions you request or authorize, or maintaining your policy or contract;
- Courts and government agencies in response to court orders or legal investigations;
- Credit bureaus; and
- Other financial institutions with whom we may jointly market products, if permitted in your state.

In addition, we may share certain of your personal information with your MassMutual financial professional, if he or she is a career agent of ours who terminates their relationship with us to join another financial institution (whom we call a "departing MassMutual financial professional") so that he or she can continue to work with you at his or her new company.

Please note that any personal information consisting of medical or health information is only shared with third parties to perform business, professional or insurance functions on our behalf or as authorized by you.

Important privacy choices. MassMutual respects your privacy choices. If you have a relationship with a departing MassMutual financial professional, as described above, and you prefer that we do not share your personal information, such as information about your insurance policies or contracts held with us, with him or her under these circumstances, you can opt out of this sharing by directing us not to do so. If you wish to opt out of the sharing of your personal information with your departing MassMutual financial professional, you may:

- Call us at (800) 272-2216.

You may make this privacy choice and contact us at any time, however, if we do not hear from you we may share your information with your departing MassMutual financial professional as described above. If this is a joint account, if one joint owner tells us not to share information that choice will apply to the other owner or owners. If you have already told us your choice, there is no need to do so again.

If you have not purchased a product or service through a MassMutual financial professional or you do not have a relationship with a MassMutual financial professional, as described above, you do not need to contact us as we will not share your personal information other than as described in this notice.

Other than as described above, we will only share your personal information as permitted by law and, if the law requires us to obtain your consent or give you the opportunity to opt out of some types of sharing, we will do so before sharing the information.

Certain state laws may provide residents with additional protections for personal information. If you are a resident of one of the following states, we will not share your personal information with your departing MassMutual financial professional unless we receive your express consent:

Arizona	Massachusetts	North Carolina
California	Minnesota	North Dakota
Connecticut	Montana	Ohio
Georgia	Nevada	Oregon
Illinois	New Jersey	Vermont
Maine	New Mexico	Virginia

If you are no longer our customer, we may continue to share your personal information as described in this Privacy Notice.

If you have any questions or concerns about this Privacy Notice, please contact us at (800) 272-2216.

Consumer Notification

This notice is to inform you that a consumer report or an investigative consumer report may be obtained from a consumer reporting agency for the purpose of evaluating your insurance application. The report may contain information bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living, which has been obtained from public record sources or through interviews with you, your family, neighbors, friends or associates. You have a right to receive a copy of the investigative consumer report from the consumer reporting agency that conducts the investigation.

Medical Information Bureau Notice

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the MIB Inc., formerly 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 in its file.

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

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

The purpose of the bureau is to protect its member companies and their policyholders from the costs created by people who try to hide facts about their insurability. Information furnished by the bureau cannot be used as a basis for evaluating risks. However, it may be used to alert us to the possible need for further investigation. THE BUREAU DOES NOT HAVE MEDICAL REPORTS FROM HOSPITALS AND DOCTORS. THE INFORMATION IN ITS FILES DOES NOT SHOW WHETHER AN INSURANCE APPLICATION WAS ACCEPTED, PLACED IN AN INCREASED PREMIUM CLASS OR DECLINED. **(This notice is only valid where permitted by law.)**

Our Purpose

Part of our basic Company purpose is to provide insurance at the lowest possible cost. The underwriting process is necessary both to assure this low cost and to make sure that each policyholder contributes his or her fair share of the cost. The procedures described above benefit you as a policyholder, because they assist us in providing your insurance at the lowest possible cost.

This Privacy Notice is being provided on behalf of the following insurance companies: Massachusetts Mutual Life Insurance Company (MassMutual), C.M. Life Insurance Company and MML Bay State Life Insurance Company.

Massachusetts Mutual Life Insurance Company (MassMutual), Springfield, MA 01111-0001. All rights reserved. www.massmutual.com.

MassMutual

NOTICE OF INFORMATION PRACTICES

Collection of Information

In order to underwrite and administer your insurance coverage, we, the Massachusetts Mutual Life Insurance Company, or its Affiliated MML Insurance Company to whom you are applying to for insurance, must collect a certain amount of necessary and helpful information. The amount and type of information collected may vary depending upon the amount and type of coverage applied for. In general, we will be seeking information about your age, occupation, finances, physical condition, health history, mode of living, avocations, and other personal characteristics. In addition, your agent may aid in the collection of this information and collect information to update and improve your insurance program.

Sources of Information

You are our most important source of information. We may also collect or verify information by contacting medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employer and business associates, family, friends and neighbors, and other insurance companies to which you have applied. We may collect information by exchanges of correspondence, by telephone, and by personal contact. In some cases we may ask an insurance support organization to collect information and submit an investigative consumer report to us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

Disclosure of Information

Any information obtained will be treated confidentially. Under some circumstances we, or your agent, may make disclosures of personal information, without your authorization, to third parties. Some of the persons or organizations to whom certain items of information may be disclosed are as follows:

- Persons or organizations which perform business, professional, or insurance functions for us;
- Your agent, General Agent, consumer reporting agencies hired to prepare investigative reports, and other insurance companies to which you have applied for coverage or benefits;
- Your attending physician or treating medical professional.

A description of the circumstances under which information about you might be disclosed without your authorization to the types of persons and organizations referred to above will be sent to you upon request.

Access to and Correction of Information

You have a right to learn the nature and substance of any personal information about you in our files upon written request. Should you feel any information we have in our files is inaccurate, incomplete or irrelevant, you may request correction, amendment, or deletion of that information. A description of access and correction procedures will be sent to you upon your request.

Should you have any questions about the above or about our information practices please contact the Underwriting Department.

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

N170 (782)

MassMutual

HIPAA Authorization

For use with Life, DI & Life with Long Term Care Riders

This Authorization complies with HIPAA Privacy Rule. "HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended. "I", "you" and "your" refer to the Proposed Insured or Insured.

A Authorizations

- I hereby authorize the use and disclosure of my medical records, medical history and other information that relates to the diagnosis, treatment or prognosis of any physical or mental condition, whether in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs and pharmaceutical records; diagnostic testing; laboratory records; alcohol or drug use; and communicable or infectious diseases or conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases unless otherwise restricted by state law.
- This Authorization specifically excludes psychotherapy notes. Psychotherapy notes means notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session, and that are separated from the rest of any individual's medical record. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop dates, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date; therefore, such medical records are covered by this Authorization.
- I hereby authorize the following persons or entities who have provided payment, treatment or services to me or on my behalf within the past ten (10) years to disclose all medical or health information about me: a physician; medical practitioner or health care professional or provider; hospital; clinic; laboratory; medical or medically-related facility; pharmacy or pharmacy benefit manager; health plan. I further authorize the following persons or entities to disclose all medical or health information about me: any insurance company, including the Company ("Company" as referred to herein, is Massachusetts Mutual Life Insurance Company, and/or MML Bay State Life Insurance Company and/or C.M. Life Insurance Company), or reinsurance company; any consumer reporting agency such as the MIB, Inc. ("MIB"); the Department of Motor Vehicles or any other state or federal government agency; and/or any other organization, institution or person having personal health information about me.
- I hereby authorize the disclosure of my medical or health information to the Company, its service providers, its reinsurers and its agents, representatives and insurance producers (including the agents, representatives and employees of such persons or entities). I hereby authorize the disclosure of my medical or health information to any consumer reporting agency, including the MIB.
- I hereby authorize the use and disclosure of my medical or health information for purposes of and in connection with underwriting my application for insurance with the Company, determining the premium for the insurance, obtaining reinsurance, servicing my insurance and administering coverage, evaluating any claim for insurance benefits and conducting other legally permissible activities that relate to any coverage I have applied for. I understand that there may be additional uses or disclosures of my medical or health information that are specifically permitted by law without my Authorization, such as to government regulatory or law enforcement entities.

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

B Agreements & Signatures

If I do not sign this Authorization, the Company may (i) decline my application for insurance or not be able to offer me any coverage and/or (ii) decline to pay a claim for benefits under any insurance issued. Providers of health care services or medical treatment may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.

My Authorization may be revoked by sending a written request to:

MassMutual
Attn: Authorization Administrator – Underwriting Dept.
1295 State Street
Springfield, MA 01111-0001

I may not revoke any Authorization that was obtained as a condition of obtaining insurance, paying a claim, or that was relied or acted upon.

This Authorization applies to my entire medical record. Any agreements I have made to restrict my medical or health information do not apply to this Authorization.

My health information may be re-disclosed and no longer protected by HIPAA if the person receiving this information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers providing long-term care insurance and health care providers. However, the Company requires its employees, agents, representatives, insurance producers and service providers to protect the confidentiality of health information regardless of whether the employee, agent, representative, insurance producer or service provider is engaged in an insurance business subject to HIPAA. Information may only be re-disclosed in accordance with applicable laws or regulations.

This Authorization shall be valid for twenty-four (24) months from the date I sign it. A copy or facsimile of this Authorization may be relied upon as if it were an original.

I, or the Representative authorized to act on my behalf, have received a copy of this Authorization.

Some states' rules concerning Authorizations change the terms and provisions of this Authorization. By signing below, you acknowledge the conditions identified on page three are considered part of this Authorization and apply in the identified states.

Signature *(Required for all cases)*

Signature of Proposed Insured/Insured/Representative: _____

Printed name: _____ Date: _____

Proposed Insured/Insured's full legal name *(If different than above):* _____

Proposed Insured/Insured's date of birth *(mm/dd/yyyy):* _____

Relationship to Proposed Insured/Insured *(If Representative):* _____

C State-Specific Authorizations

If you reside in a state listed below, then the identified provisions apply to your Authorization.

- **ARIZONA.** With respect to disclosure of HIV-related information only, this Authorization is valid for 180 days from the date it is signed.
- **MAINE.** This Authorization excludes the disclosure of the result of a test for HIV if the Proposed Insured or Insured has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat shall otherwise prohibit this Authorization from including other facts and information relative to the fact that the Proposed Insured or Insured has AIDS.
- **MINNESOTA.** This Authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency personnel who were tested as a result of performing emergency medical services. The term **"emergency medical personnel"** includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.
- **NEW MEXICO.** "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant, proposed insured or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant, proposed insured or insured is known to have a direct, close personal, family or abuse-related counseling relationship. During the time this Authorization is valid it extends to the information required to determine eligibility for benefits under any policy issued as a result of this application.

  With respect to confidential abuse information, this Authorization may be revoked in writing, ten days after receipt by the Company, but doing so may result in an application or claim being denied or may otherwise adversely affect a pending insurance action.

  The Company may collect genetic information about you for use in conducting and administering its business of insurance. "Genetic information" means the information about a genetic makeup of a person or members of a person's family, including information resulting from genetic testing, genetic analysis, DNA composition, participation in genetic research or use of genetic services. This information may only be used, transmitted or retained for the purpose of conducting and administering its business of insurance, except with your consent or as otherwise authorized or required by law.
- **OREGON.** With respect to disclosure of HIV-related information only, this Authorization is valid for 180 days from the date it is signed.
- **VERMONT.** This Authorization does not extend to previously administered test for HIV antibodies, T-Cell counts, AIDS or ARC, nor to any medical doctor, doctor of osteopathy, physician, health care professional, hospital, clinic, medical facility, the Veterans Administration, the MIB Inc., employer, consumer reporting agencies, other insurance company, or anyone else, with respect to previous test results. I am not providing authorization for the release of results from any new test for the HIV virus to any outside, non-affiliated company nor to any company not under contract with the company to perform underwriting services.
- **VIRGINIA.** If this Authorization is used for claim purposes it is valid for the duration of the claim.