WAIVER OF PREMIUM CLAIM KIT
FOR PROCESSING OF A WAIVER CLAIM BY A THIRD PARTY ADMINISTRATOR

SOME NOTES REGARDING THE WAIVER OF PREMIUM COVERAGE

A WAIVER OF PREMIUM CLAIM SHOULD BE FILED FOR AN INSURED WHO HAS BEEN DISABLED NON-STOP AT LEAST SIX OR NINE MONTHS ACCORDING TO THE POLICY, OR FOR LESS TIME IF IT CAN BE PRESUMED THE DISABILITY WILL BE NON-STOP FOR THE REMAINDER OF THE INSURED'S LIFE.

TO BE ELIGIBLE FOR WAIVER OF PREMIUM THE INSURED MUST BE UNDER THE AGE OF SIXTY ON THE DATE THAT TOTAL DISABILITY COMMENCES.

PROOF OF TOTAL DISABILITY MUST BE RECEIVED AT THE HOME OFFICE WITHIN ONE YEAR OF THE START OF THE DISABILITY.

INSTRUCTIONS FOR FILING A WAIVER OF PREMIUM CLAIM

PLEASE SUBMIT THE FOLLOWING:

1. THE CLAIM FORM FULLY COMPLETED:
   PAGE 2 FULLY COMPLETED BY THE THIRD PARTY ADMINISTRATOR AND EMPLOYER.
   PAGE 3 FULLY COMPLETED BY THE INSURED.
   PAGE 4 FULLY COMPLETED BY THE ATTENDING PHYSICIAN WHO CAN VERIFY THAT THE INSURED IS TOTALLY DISABLED.

THIS FORM MUST BE FULLY COMPLETED TO PREVENT UNNECESSARY TIME DELAY IN CLAIM PROCESSING

2. PLEASE ATTACH TO THE FULLY COMPLETED CLAIM FORM ANY MEDICAL DOCUMENTATION WHICH MAY ASSIST US IN THE EVALUATION OF THE CLAIM FOR WAIVER OF PREMIUM BENEFITS.

3. HIPAA-COMPLIANT AUTHORIZATION FORM SHOULD BE FULLY COMPLETED BY THE INSURED.

IF YOU SHOULD NEED ASSISTANCE IN THE COMPLETION OF THE CLAIM FORM
PLEASE CALL (877) 212-2950 OPTION 3

Please see Fraud Notice

CL14 (W)
Rev 10/13

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 ROYALL ST · CANTON MA 02021 · 781-828-7000 or 1-877-212-2950

Employer's Statement

Name of Employee:	Policy No:	Certificate:
Birth date:	Date of Employment:	No. Hours worked each week:
Date Employee Enrolled for Insurance:	Annual Earnings:	
Effective Date of Life Insurance Employee_____ Dependent _____	Amount of Insurance Basic _____ Supplemental _____	Dependent Coverage Spouse _____ Children _____
Was Employee at work on Effective Date? ☐ Yes ☐ No	Was Insured Considered an Employee at time of Disability? ☐ Yes ☐ No	
Date of Disability:	Date Last Worked:	Occupation:
Normal Retirement age in Company:	Brief Description of Duties:	

I hereby certify that the above named employee was insured under this policy and the coverage was in force with premium paid as of the date of disability.

_____
Signature of Authorized Representative

Date: _____

_____
Employer

_____
Street City/Town State Zip

_____
Area Code Telephone Ext.

Administrator's Statement

Name of Insured:	Date of Birth:	Date of Disability:
Policy No:	Certificate No:	Effective Date of Insurance:
Amount of Insurance Basic _____ Supplemental _____	Dependent Coverage Spouse _____ Children _____	Was Insurance subject to Medical Evidence of Insurability? ☐ Yes ☐ No

I hereby certify that the above named insured was covered under this policy and coverage was in force with premium paid as of the date of disability.

Signature and Address of Administrator

Date: _____ _____

Telephone # _____ _____

_____

WAIVER OF PREMIUM

Insured's Statement

Name: _____ Policy No: _____

Address: _____ Date of Birth: _____

_____ Social Security No: _____

Name of Employer: _____ Telephone No: _____

Address: _____

_____ Occupation: _____

Brief Description of Duties: _____

Exact Date Last Worked: _____ Date you became Totally Disabled: _____

Date your illness/injury prevented you from working: _____

Date of injury, if applicable: _____ Date you expect to return to work: _____

Briefly describe your illness or injury: _____

_____

LIST BELOW IN DATE ORDER ALL PHYSICIANS AND HOSPITALS WHERE YOU RECEIVED MEDICAL TREATMENT:

Physicians and/or Hospitals	Date(s) Treated
_____	_____
_____	_____
_____	_____
_____	_____

YOUR EDUCATIONAL BACKGROUND

Highest Grade Completed: _____ Degrees if any: _____

Brief Description of Past Work Experience: _____

_____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. **Please refer to "Fraud Warning Notices" insert for your state.**

X_____/_____/_____

Signature of Insured Printed Signature Date

Note: Insured is Responsible for any cost involved in the completion of this Attending Physician's Statement

WAIVER OF PREMIUM CLAIM **ATTENDING PHYSICIAN'S STATEMENT**

Insured: _____ Date of Birth: _____

MEDICAL HISTORY

Date Illness/Injury began: _____ First Date of Total Disability: _____

Date of First Treatment: _____ Date of Last Treatment: _____

Prior Problem? Yes ☐ No ☐ Date(s) of Prior Problem: _____

PRESENT CONDITION

Diagnosis: _____

Symptoms: _____

Tests Conducted: (i.e. x-rays, EKG, etc.) _____

Medications Prescribed: _____

Progress: ☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

Names and Addresses of other Attending Physicians and Hospitals

Name Address

_____

_____

_____

DURATION

Do you consider Insured totally and permanently disabled from performing his present occupation or any other Gainful occupation? Yes ☐ No ☐

Will insured be able to return to any type of work? Yes ☐ No ☐

As of What Date: _____

Limits, if any: _____

_____

Date: _____ **Signature: _____**

Physician's Full Name: _____ **Telephone No: _____**

Address: _____

NOTICE OF INFORMATION PRIVACY PRACTICES

Boston Mutual Life Insurance Company
(Herein referred to as "we", "us", "our")

Your privacy is important to us. We believe in ensuring the privacy of the information you give to us. This notice describes our privacy practices.

We restrict access to your non-public personal information *("information")* about you. We restrict it to those employees who have a need to know it. They need it to provide products and services to you. To protect your information, we maintain: physical; electronic; and procedural safeguards.

COLLECTING INFORMATION

We collect financial and health information about you in order to conduct business. Such uses are: to process requests for insurance products; to provide customer service; to process claims; to fulfill legal and regulatory requirements; and for other lawful purposes. We collect this information from you as well as from other sources.

Information we need to collect varies according to the products and services you request. It may include information from:

- your applications and other forms.
- other transactions you've had with us.
- consumer reporting agencies.
- your medical providers and health records.
- other sources.

SHARING INFORMATION

We treat the information we have collected about you in a confidential way. We do not disclose information about our customers or former customers to anyone, except as permitted or required by law.

We may share your information with third parties without your authorization as permitted by law. Such information is used to:

- process or service your insurance transactions with us.
- perform underwriting, administrative, account maintenance and claims functions.
- provide customer service or reinsurance coverage.
- protect against fraud.
- or perform other business functions on our behalf.

We may also share your information with:

- a consumer reporting agency in accordance with the Fair Credit Reporting Act.
- a third party to comply with federal, state or local laws, subpoenas or summonses.
- or as otherwise permitted or required by law.

Third parties receiving information from us are required to: keep it confidential; and to comply with all applicable federal and state privacy laws.

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

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

Boston Mutual Life Insurance Company, or its reinsurers, may also release information from its 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.

ADVERSE UNDERWRITING DECISION

You have the right to be advised in writing of the specific reasons for an adverse underwriting decision. Such decisions include:

- declining your application for insurance.
- offers to insure you at a higher than standard rate.
- termination of your coverage.

You must request this information in writing within 90 days from the date we mail you notice of the decision. We will furnish you with a statement of the specific reason for our decision within 21 days of receiving your written request for it.

ACCESS TO YOUR PERSONAL INFORMATION WE HAVE IN OUR RECORDS

You have the right to obtain access to all the information we have on you. You have the right to request: the amendment; correction; or deletion of such information. To do so, write us at the address below.

If you have questions about this notice or wish more information about our privacy policies, please write us at:

Boston Mutual Life Insurance Company
Attention: Privacy Office
120 Royall Street, Canton, MA 02021

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH Rev. Stat. Ann. 638:20.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.