The Savings Bank Mutual Life Insurance Company of Massachusetts

Policy Change Request

Policy Number(s): _____

Name of Insured: _____

Name of Policyowner(s): _____
(if other than insured)

Please indicate the type of change requested:

[X] Change from Smoker to Non Smoker Rate

I hereby request that the premium classification under each of the above policies be changed to a Non-Smoker rate.*

***This request for change will be subject to additional underwriting review and should only be requested when the condition causing a higher premium classification is subsequently rectified or stabilizes. Based on this review, you may qualify for a lower premium classification.**

Important Notice Regarding Requests for change in Smoker Rate:

This type of change can only be made to policies issued on or after 6-1-84 to Insured's who are over age 18, have not used any form of tobacco or any other nicotine product or by product for at least two years and are currently in good health. A history of heart, lung or arterial - sclerotic disease or any other condition that may be secondary to a history of smoking will result in the declination of a request for non-smoker rates. If the Insured's health history includes such a condition, you should not submit a request for change in rate classification.

I understand that this change may result in a proportionate reduction in the premium and dividend amounts as well as the cash value. If the policy has cash value and will be reduced by this change, I agree to the surrender of any excess cash value; which exceeds the value required to maintain the policy. I understand a cash payment will be made to me in a lump sum for this amount.

I hereby request that SBLI waive any requirement that this change be endorsed on the original policy. I agree that the change herein requested shall be assumed to become effective without such endorsement, and I further agree that acknowledgment of receipt of this form by SBLI shall be construed as a waiver of the requirement of any such endorsement without further acknowledgment or notice by it.

If the policy is currently under collateral assignment, the Assignee must sign below; otherwise, the Policyowner must sign.

X _____ _____
Signature of Policyowner **Date**

If the Beneficiary has been designated "without power of revocation", the Beneficiary must sign below.

X _____ _____
Irrevocable Beneficiary **Date**

DO NOT MAIL POLICY
When processed, an acknowledgment will be sent to you for your records

For Internal Use Only: Rating Change _____ Premium Classification Change_____

Return completed form to:

The Savings Bank Mutual Life Insurance Company of Massachusetts
P.O. Box 4048
Woburn,MA 01888

Note: The following section is relative to the Insured under this policy and must be completed by the Insured.

Insured Information:

Who is your personal physician? (If you do not have one, so state.)

Name: _____

Address: _____

City, State, Zip: _____

Tel. No.: _____

Date of Last Visit: _____

What is your height? _____Feet _____Inches

What is your weight? _____lbs.

If you lost weight in the past year, please state how much: ___lbs.

and the reason for the loss: _____

What is your current occupation: _____

Please answer each of the following questions and provide details below for all questions answered **"YES"** *

1. Within the **last 2 years**, have you:
   a) Consulted or been treated by a physician or other practitioner for any illness or symptom thereof? ❑ Yes ❑ No
   b) Been in a hospital, clinic or institution for examination, observation, diagnosis, surgical procedure or treatment? ❑ Yes ❑ No
   c) Are you now taking, or have you been advised to take, any medications? ❑ Yes ❑ No
   d) Engaged in or expected to engage in aviation activities (other than commercial airline/airplane), or hazardous sports, avocations or hobbies? ❑ Yes ❑ No
2. Within the **last 3 years**, have you resided or traveled, or do you intend to reside or travel outside the U.S.? ❑ Yes ❑ No
3. Are you, or do you intend to become, a member of the Armed Forces, including Reserves? ❑ Yes ❑ No
4. Have you **ever**:
   a) Received any moving violation, had a driver's license suspended or revoked, been convicted of reckless driving, driving to endanger, driving under the influence of drugs and/or alcohol? ❑ Yes ❑ No
   b) Been advised by a physician, psychiatrist or psychologist to quit or reduce alcohol use? ❑ Yes ❑ No
   c) Ever used or been convicted of drug possession or distribution? ❑ Yes ❑ No
   d) Attempted suicide? ❑ Yes ❑ No
   e) Used any form of tobacco or any other nicotine product or by product? If "Yes" indicate, ❑ Yes ❑ No
   Product Type: _____ Quantity and Frequency of Use: _____
   Date Last Used: _____ How Long Used: _____

*** Provide complete details in the space below for any "YES" answers to questions 1-4 above.**

Question #	Date(s)	Details of "YES" Answers	Names and addresses of any physician, practitioner, hospital, clinic or institution involved.

Authorization:

The statements made herein are true to the best of my knowledge and belief and are made for the purpose of inducing The Savings Bank Mutual Life Insurance Company of Massachusetts (the Company) to grant the change requested on the reverse side under each of the named policies. I agree (1) that any benefit requested herein shall not take effect until any cost to change is paid and the approval of the request is acknowledged by the Company while the insured is in good health (2) acknowledgement of this change may be attached to and made part of each of the above named policies.

ABBREVIATED NOTICE OF INFORMATION PRACTICES: Personal information about you may be collected from other parties. Personal and privileged information about you may in certain circumstances be disclosed to third parties without your authorization. You have a right of access to all such personal information collected and you have the right to correct any erroneous or misleading personal information. Upon written request, we will provide you with a Comprehensive Notice of Information Practices.

AUTHORIZATION: In connection with a request for change in coverage, I hereby authorize any physician, medical practitioner, health care provider, hospital, clinic, insurance company, the Medical Information Bureau (MIB) or any other organization or person that has records or knowledge of me or my health to give such information to the Medical Director of The Savings Bank Mutual Life Insurance Company of Massachusetts (the Company) or any consumer reporting agency acting on its behalf. This may include, but is not limited to findings or records of: medical care, examinations, psychiatric or psychological care, drug or alcohol use history or previous disability or surgery.

I further authorize the Company to release any information obtained by this authorization to MIB, to other insurers in which I have policies or to which I may apply or to which a claim for benefits may be submitted, to reinsurers, and to other persons or organizations performing legal or business services in connection with my application. I further authorize the Company to obtain an investigative consumer report on me and I understand that I have a right to request to be interviewed in connection with the preparation of any such report. A photocopy of this form shall be as valid as the original and I understand that I may have a copy of this form upon request. The authorization is valid for 30 months (24 months if RI laws apply) from the date of my signature below. By signing below I agree to the terms of this authorization and acknowledge that I have read and understand it.

Any person who, knowingly and with the intent to defraud or deceive any insurance company, makes any representation, which is false or conceals for the purpose of misleading, information concerning any fact material thereto commence a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

X_____ X_____

Signature of Insured (Parent or Guardian, if Insured is less than 18) **Date**

The Savings Bank Mutual Life Insurance Company of Massachusetts
One Linscott Road, Woburn MA 01801
Telephone (800) 694-7254 ~ www.sbli.com

Name of Insured (print) _____ Date of Birth _____ Social Security Number _____

AUTHORIZATION TO COLLECT AND DISCLOSE RECORDS

This Authorization complies with the Health Insurance Portability and Accountability Act ("HIPAA")

I hereby authorize all the entities listed below that have provided payments, treatments, or services to me, or on my behalf, to disclose to The Savings Bank Mutual Life Insurance Company of Massachusetts (the "Company") and its Producers, employees and representatives, including insurance support organizations, the following information: any and all information relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments or surgeries, hospital confinements for physical and mental conditions, use of alcohol, drugs, and tobacco; drug prescriptions and communicable diseases, including Human Immunodeficiency Virus (HIV) and AIDS, and any other personal information about me.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician, medical practitioner, or health care professional;
- any hospital, laboratory, pharmacy, pharmacy benefit manager, clinic or other health care facility or provider;
- any insurance company or reinsurance company;
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- MIB Inc. (MIB)

This information may be disclosed pursuant to this authorization so that the Company can use it to:

- determine my eligibility for insurance;
- underwrite my application and make risk rating, policy issuance and enrollment determinations;
- determine my eligibility for benefits under the Conditional Receipt Agreement;
- obtain reinsurance;
- if a policy is issued or reinstated, administer coverage, administer claims, and determine or fulfill responsibility for coverage and provision of benefits; and
- conduct other legally permissible activities that relate to any insurance coverage I have or have applied for with the Company.

- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, medical practitioner, hospital, clinic, or other health care provider to release and disclose my entire medical record without restriction. I understand that my health care providers cannot refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.
- I further authorize the Company to release any information obtained by this authorization to MIB Inc., other insurers in which I have policies or to which I may apply or to which a claim for benefits may be submitted, to reinsurers, and to other persons or organizations performing legal or business services in connection with my application or claim. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.
- I authorize the Company to release to me, or to my physician, results that I may request of any medical or laboratory tests taken in connection with this application.
- I also understand that failure to sign this Authorization statement, or the subsequent revocation of this Authorization by me, may impair the ability of the Company to process my application or evaluate claims; and may be a basis for denying an application or claim for benefits.
- By signing below I agree to the terms of this Authorization and acknowledge that I have read and understand it.

I may revoke this Authorization in writing at any time, except to the extent that action has been taken in reliance of this Authorization or to the extent the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself, by sending a written request to: The Savings Bank Mutual Life Insurance Company, P.O. Box 4048, Woburn, MA 01888.

This authorization shall remain in force for 24 months following the date of my signature below or for the duration of any claim for benefits. A copy of this authorization is as valid as the original. I acknowledge that I have received a copy of this authorization.

FOR MAINE and VERMONT APPLICANTS, this Authorization excludes the release of any information relating to previously administered test for HIV antibodies, T-Cell counts, AIDS or ARC, by the applicants family/regular/attending medical doctor/physician/practitioner or care giver or any other person or entity which may possess this information. This exclusion extends to any medical doctor, doctor of osteopathy, physician health care professional, hospital, clinic, medical facility, the Veterans Administration, employer, consumer, reporting agencies, other insurance companies, or anyone else with respect to previous test results. The applicant is not authorizing the Company to forward the results from any new test, requested of the applicant by the Company to an outside, non-affiliated company, nor to any entity not under specific contract with the Company to perform underwriting services.

Date: _____ **Signature of Insured*: X**_____

*If the insured is under the age of 18,
signature of ☐ Parent ☐ Guardian ☐ Other: **X** _____