BOSTON MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 120 Royall Street • Canton, MA 02021
TEL (877) 212-2950

FAMILY MATTERS. NO MATTER WHAT.®

LIFE CLAIM KIT
FOR PROCESSING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS

INSTRUCTIONS FOR FILING A LIFE CLAIM

On behalf of Boston Mutual Life Insurance Company, please accept our sincere condolences for your loss. We realize that this is a difficult time for you and your family and we will make every effort to process your claim promptly.

To expedite the processing of your claim, it is important that you submit all of the necessary information requested below.

1. The claim form should be fully completed by the named beneficiary or their authorized representative and signed where indicated. If more than one named beneficiary, please use the Additional Beneficiary form.
2. A clear photocopy of the death certificate for the insured.
3. The insurance policy. If the policy cannot be found, please complete the lost policy section of the claim form.
4. If claim is being made for accidental death benefits, the named beneficiary must also complete the Accidental Death Claim form. Applicable police and accident reports should also be attached.
5. If the coverage was paid for in full or in part by the Employer, or if this is group coverage and the Employer maintains the enrollment forms, an authorized representative of the employer must complete the Employer's Statement. All original enrollment forms and beneficiary changes must also be included with the claim.
6. Each beneficiary should complete the Life Insurance Payment Options form.
7. A HIPAA - Compliant authorization form should be completed by the named beneficiary *(or next of kin if named beneficiary is not next of kin)* if the coverage has been inforce less than two years.
8. If proceeds are assigned to a funeral home, we must be provided with the assignment form and the funeral bill if required by state.
9. Please read the "Fraud Warning Notice" for your state.
10. If you are a California consumer, please visit our website at www.bostonmutual.com for our California privacy notice.

*** * * Policies that have been in force less than two years could be contestable * * ***

If you should need assistance in the completion of the claim form
Please call 877-212-2950
Mail forms to: Boston Mutual Life Insurance Company, 120 Royall Street • Canton MA 02021

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LIFE CLAIM FORM

Policy Numbers of the Company under which claim is made by the undersigned

#1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Full Name of Insured _____ Married ☐ Widowed ☐

Address _____ Single ☐ Divorced ☐

Is Insured Known by any other name? YES ☐ NO ☐ If YES, please advise _____

Date of Birth _____ Date of Death _____ Soc. Sec. No. _____

Date Last Worked *(if known)* _____ Name of Employer _____

Please complete the following if Policy was in force less than 2 years and include a signed HIPAA-Compliant Authorization for the release of medical records.

Full Names and Addresses of all Physicians and Hospitals where insured was treated in last 5 years

	Name	Address	Telephone No.
1.			
2.			
3.			

BENEFICIARY'S INFORMATION

Beneficiary's Name _____ Beneficiary's Social Security No. _____

Beneficiary's Date of Birth _____ Beneficiary's Telephone No. _____ Beneficiary's Relationship _____

Beneficiary's Address _____

Beneficiary's Mailing Address *(if different)* _____

CERTIFICATION – 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 Beneficiary | Printed Name | Date

STATEMENT OF POLICY LOSS *(To be completed only if original policy could not be found after a thorough search)*

Insured _____ Policy No _____

This policy was lost or destroyed. If the policy is found later, I agree to surrender it to the company without claim.

X _____ _____ _____
Signature of Beneficiary | Date | Signature of Witness

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ACCIDENTAL DEATH CLAIM FORM

Beneficiary must fully complete this section if claiming Accidental Death Benefit

Insured's Name: _____

Date and time of accident causing death: Place of Death: Highway ☐ Home ☐ Work ☐

Date: _____ 20____ AM ☐ PM ☐ Recreation ☐ Other ☐ _____

Describe Accident in detail: ***(Please send copies of police reports, newspaper articles etc. to help in the processing of this claim)***

_____

_____

_____

_____

_____

Names of PHYSICIANS and HOSPITALS where Insured received treatment

Name	Address

Was an Autopsy Performed? YES ☐ NO ☐ If YES, by whom, where and date.

Name	Address	Date

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X _____ _____ _____

Signature of Beneficiary | Printed Name | Date

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EMPLOYER'S STATEMENT

This form must be completed by an authorized representative of the Employer if the coverage was paid for in full or in part by the Employer, or if this is group coverage and the Employer maintains the enrollment forms.

LIFE CLAIM

Name of Insured: _____ Group Policy No: _____ Div. _____

Is Insured known by any other name: YES ☐ NO ☐ If YES, please advise: _____

Address of Insured: _____ Certificate No: _____

Date Insured Last Worked: _____ Date of Death: _____ Amount of Insurance: _____

No. of Hours worked each week: _____ Annual Earnings as of date last worked: _____

Reason for leaving work: Disability ☐ Resignation ☐ Vacation ☐ Leave of Absence ☐ Retired ☐
Lay Off ☐ Dismissed ☐ Other ☐ *(Specify)* _____

Was Insured an Employee at time of death? YES ☐ NO ☐ Insured's Occupation: _____

Date Employed: _____ Date of Birth: _____ Effective Date of Insurance: _____

Was Insurance terminated prior to death? YES ☐ NO ☐ If YES, date of termination and reason: _____

DEPENDENT LIFE CLAIM

Name of Dependent: _____ Date of Birth: _____ Date of Death: _____

Address of Dependent: _____
Street City/Town State Zip

Was Insurance terminated prior to death? YES ☐ NO ☐ If YES, date of termination and reason: _____

I hereby certify that the date through which premium for this Insured has been paid is: _____
Month/Day/Year

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X _____ _____
Signature of Authorized Representative Street City/Town State Zip

_____ _____
Employer Area Code Telephone Ext.

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ADDITIONAL BENEFICIARY STATEMENT

(To be completed if there is more than one beneficiary)

Name of Insured: _____ **Policy #:** _____

Beneficiary's Name: _____ Beneficiary's Social Security # _____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

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X _____ _____ _____
Signature of Beneficiary | Printed Name | Date

Beneficiary's Name: _____ Beneficiary's Social Security # _____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

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X _____ _____ _____
Signature of Beneficiary | Printed Name | Date

Beneficiary's Name: _____ Beneficiary's Social Security # _____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

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X _____ _____ _____
Signature of Beneficiary | Printed Name | Date

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LIFE INSURANCE PAYMENT OPTIONS

Please review the following payment options and select your option by checking the appropriate box and signing this form. Payment options may vary based on the policy selected. Please consult the policy for available options. If you have any questions or would like to discuss other payment options, please call our Claim Services team at 1-877-212-2950. Please return this form with your claim.

☐ **Lump sum payment.** By choosing this option, you are electing to receive the proceeds due in one lump sum payment. *(This is the most common payment option)*

☐ **Sum Payable as monthly income for a fixed number of years.** By choosing this option, you are electing to leave the Sum Payable with Boston Mutual Life Insurance Company. You will receive a monthly income for up to 20 years. We will pay an income once a month for the number of years chosen and the first payment will begin one month after the payment option date. Please circle the number of years you wish to receive this monthly income. The monthly income will be the payment amount for each $1,000 of sum payable next to the number of years chosen. We will pay interest on the amount left with us at a rate of at least 2 ½% per year.

MONTHLY PAYMENT FOR EACH $1,000 OF SUM PAYABLE

YEARS	PAYMENT	YEARS	PAYMENT
1	84.28	11	8.64
2	42.66	12	8.02
3	28.79	13	7.49
4	21.86	14	7.03
5	17.70	15	6.64
6	14.93	16	6.30
7	12.95	17	6.00
8	11.47	18	5.73
9	10.32	19	5.49
10	9.39	20	5.27

☐ **Interest Income.** By choosing this option, you are electing to leave the Sum Payable with Boston Mutual Life Insurance Company. We will pay interest on the amount left on deposit at a rate of at least 2 ½ % per year. The interest will be paid once a year and the first payment will be issued one year after the Payment Option Date. You may choose the number of years, up to 15 years, to receive the interest income. The payee may withdraw all or a part of the Sum Payable at any time, but may not withdraw any amount if less than $1,000 will be left with us. In this case, the payee must withdraw the full amount. Please advise the number of years _____.

☐ **Sum Payable as monthly income of a fixed amount.** By choosing this option, you are electing to leave the Sum Payable with Boston Mutual Life Insurance Company and choosing, subject to our consent, an amount of monthly income that you will receive. Monthly payments must be at least $5.00 for each $1000 of Sum Payable. The first payment will begin as of the payment option date. We will credit interest on the balance of the Sum Payable left with us. This interest will be a rate of at least 2 ½% a year, compounded once a year. Payment will last until the Sum Payable, plus interest runs out.

Date

X
Signature of Beneficiary

Printed Name

Insured's Name

*** Interest earned on the Sum Payable left with Boston Mutual Life Insurance Company may be taxable. Please consult your tax advisor ***

NOTICE OF INFORMATION PRIVACY PRACTICES

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

BOSTON MUTUAL LIFE INSURANCE COMPANY – 1891–

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PROTECTING YOUR INFORMATION

To protect your nonpublic personal information, we maintain: physical, electronic and procedural safeguards.

COLLECTING INFORMATION

We collect 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. We restrict access to your information to those working on our behalf who have a need to know it in order for us to provide products and services to you. We require them to secure the information and keep it confidential.

- ***Information we collect may include all the information you share with us including, for example, your:***
  - name
  - address
  - telephone number
  - date of birth
  - social security or tax identification number
  - employer name and income
  - beneficiary data
  - financial account numbers
  - medical information
  - and other information you share with us
- ***We may also collect data we receive from other sources, as allowed by law, which may include:***
  - medical information
  - consumer report information in accordance with the Fair Credit Reporting Act
  - participant information from organizations that purchase products or services from us for the benefit of their members or employees, such as group insurance
  - information to assist us in complying with state and federal laws

SHARING INFORMATION

We do not share information about our customers or former customers with 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 on our behalf by these third parties to:***
  - process or service your insurance transactions with us
  - perform underwriting, administrative, account maintenance and claims functions
  - provide customer service or reinsurance coverage
  - prevent fraud
  - 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
  - regulators
  - 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.

ACCESS TO YOUR INFORMATION WE HAVE IN OUR RECORDS

You have the right to request access to all the information we have on you. You must make your request in writing at the address below.

AMENDMENTS TO YOUR INFORMATION

You have the right to request an amendment, correction or deletion of information which we hold about you which you believe may be inaccurate. We are not obligated to make updates to your data based on your request. You must make the request in writing and state the reasons you are requesting the change. Write us at the address below.

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

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

420-012 3/15

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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.

see other side

FRAUD WARNING NOTICES – For Use with Claim Forms *(cont.)*

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 of 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.

RHODE ISLAND: 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.

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: ANY PERSON WHO, WITH THE 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 HAVE VIOLATED THE STATE LAW.

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.