INDIVIDUAL 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 (page 2) fully completed by the named beneficiary or their authorized representative and signed where indicated.

2. A certified death certificate of the insured. **Photocopies are not acceptable**. This normally can be obtained through the Funeral Director.

3. The insurance policy. If the policy cannot be found, the lost policy section of the claim form must be completed.

4. If claim is being made for accidental death benefits, then page 3 must also be fully completed by the named beneficiary. Applicable police reports and newspaper articles should also be attached.

5. A HIPAA-Compliant authorization form should be fully completed by the named beneficiary or next of kin if named beneficiary is not next of kin.

6. If proceeds are assigned to a funeral home, we must be provided with the assignment form and the funeral bill.

7. Review the **"FRAUD WARNING NOTICES"** for your state.

PROCESSING OF CLAIMS

EMPLOYEE SECURITY OPTION PLANS
The guaranteed issue portion (i.e. the coverage that was issued without medical information) can usually be processed immediately.

The simplified issue portion (i.e. the coverage that was issued based on medical information given) could be contestable if policy was in force less than two years.

ALL OTHER LIFE INSURANCE PLANS
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 (800) 669-2668 ext. 531
Mail forms to: Boston Mutual Life, 120 Royall St, Canton MA 02021

CL9 Rev 3/10
Expires 3/13

MAIL FORMS TO: BOSTON MUTUAL LIFE INSURANCE COMPANY

120 Royall Street · Canton · Massachusetts 02021 · 1-800-669-2668 or 781-828-7000

LIFE CLAIM FORM

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

_____ _____ _____ _____ _____

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 _____ Name of Employer _____

Please complete the following if Policy was in force less than 2 years from the Policy Issue Date

Full Names and Addresses of all Physicians and Hospitals where insured was treated

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 Address _____

Mailing Address, if different _____

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 Signature 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.

_____ _____ _____

Signature of Beneficiary Date Signature of Witness

Expires 3/13

ACCIDENTAL DEATH CLAIM

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 ☐

_____20__ _____a.m. _____p.m. Work ☐ 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 Autopsy Performed? ☐ Yes ☐ No If yes, by whom, where, and date.

Name	Address	Date
_____	_____	_____

Expires 3/13

LIFE INSURANCE PAYMENT OPTIONS

Please review the following payment options then check off the box next to the option that you wish to receive. Please sign the form and return to Boston Mutual Life Insurance with your claim.
Should you have any questions, the Claim Department may be reached by calling 1-800-669-2668 or writing to: Claim Department, Boston Mutual Life Ins. Co., 120 Royall St, Canton MA 02021.

❑ **Lump Sum Payment.**

❑ **Interest Income. The beneficiary leaves the Sum Payable with Boston Mutual Life. We will pay interest on the amount left with us 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. The payee chooses 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.**

❑ **The payee receives Sum Payable as monthly income for a fixed number of years. The payee leaves the Sum Payable with us and chooses the number of years, up to 20, to receive monthly income. We will pay an income once a month for the number of years chosen and the first payment as of the payment option date. The amount of each payment is shown in the table below.**

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

❑ **The payee receives Sum Payable as Monthly Income of a Fixed Amount. The payee leaves the Sum Payable with us; chooses, subject to our consent, an amount of monthly income that he or she will receive. Payments must be at least $5.00 for each $1000 of Sum Payable. The first payment starts 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: _____ Signature of Beneficiary _____

Policy Number: _____ Insured's Name:_____

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

Additional Beneficiary Statement

To be completed if there is more than one beneficiary

Name of Insured: _____ Policy #: _____

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

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

Beneficiary's Address _____

Mailing Address, if different _____

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 Signature Date

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

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

Beneficiary's Address _____

Mailing Address, if different _____

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 Signature Date

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

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

Beneficiary's Address _____

Mailing Address, if different _____

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 Signature Date

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 RSA 638:20.

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

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.

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: 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.

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