MICHIGAN VERSION

Disability Income Insurance Change Application Package

Disability

THIS PACKAGE MAY BE USED FOR:	Policy changes to all in-force Disability Insurance products.
USE THIS PACKAGE IN THE FOLLOWING CONTRACT STATE:	Michigan
THIS PACKAGE INCLUDES:	• Application for Changes to Disability Income Insurance (F200-07) • Agent's Certificate (F6973) • HIPAA Authorization/Personal Health-Related Information (F8186) • HIV Consent Form (N201MI) • Disclosure Statement/Policy Premium Payment Options (COR4565a) • Important Privacy and Consumer Information (N2000)
CHECKLIST:	☐ Submit appropriate financial documentation (tax forms and schedules) as stated in the Disability Income Reference Manual. ☐ Provide Client with all required notices and give to applicant. ☐ Conditional Receipt – Complete receipt if prepayment is collected and give the premium payer their portion of the receipt. All checks must be made out to "MassMutual." ☐ Supplements – Attach appropriate supplements, if required, to include: • Avocation Supplement (A3320) • Replacement Form • Foreign Travel (F6290)
IMPORTANT REMINDERS:	• The Insured must always sign. • The Owner, if other than the insured must always sign. • If Owner is a corporation, include full name of corporation and print full name and corporate title of each officer who signs. • The Assignee must always sign. Include full name of Assignee and title(s) (if corporate Assignee) of officer(s) signing. • Do not use this application for reinstatements; instead, use the appropriate state version of the REIN-97 (except New York) and appropriate supplements. • This application can be used for adding Riders – Current Product Offering only* *MaxElect, Radius, BuySell and BOE

THE FOLLOWING ARE GUIDELINES FOR COMPLETING THIS PACKAGE:

Please note more than one Section may apply.

Section:	Complete For:
A (insured info.)	All policy changes.
B	Changes that do not require underwriting.
C (Occupational Data)	All changes requiring medical and financial underwriting.
D	Option Exercises (FIO/DIPR), Conversions, Benefit Renewals, Occupational Class Changes.
E	Changes Requiring Medical & Financial Underwriting: such as, Add Rider.
F	Changes Requiring Medical Underwriting: such as, Reconsider Substandard Rating.
G (Evidence of Insurability)	Changes requiring any medical underwriting.
H (Financial Data)	Changes requiring financial underwriting.
I	Changes Buy/Sell.
J	Changes to the Business Overhead Expense (BOE) product.
K (Nonmedical Part 2)	Changes requiring medical underwriting.
L (Agreement and Signature)	All policy changes.

MassMutual FINANCIAL GROUP®

Massachusetts Mutual Life Insurance Company
and affiliates, Springfield, MA 01111-0001

www.massmutual.com

DIPC-MI 0714

MassMutual
FINANCIAL GROUP℠

Agency Number _____

Massachusetts Mutual Life Insurance Company
Springfield, MA 01111-0001

Application for Changes to Disability Income Insurance (Part 1)

For:

- ☐ Exercise of DIPR, BIPR, FIO, GSR FIO
- ☐ Addition of Rider Coverage
- ☐ Adjustment of Substandard Rating
- ☐ Adjustment of Exclusion Rider
- ☐ Change in Occupation Class
- ☐ AIB/AABI Renewals
- ☐ AABI Special 5th Year
- ☐ Change in Waiting Period or Benefit Period
- ☐ GSR Conversion
- ☐ Conversion
- ☐ Renewal of Coverage after Age 65
- ☐ AIR Fifth Year Renewal
- ☐ Change in Smoker Status/Tobacco Use
- ☐ Other _____

Policy No.(s) _____

If this application relates to more than one policy, the transactions applied for are to be clearly identified for each policy.

A Insured Information

Complete this section for all changes

1. Name (First, Middle, Last)
_____

2. Sex ☐ Female ☐ Male

3. DOB _____ /_____ /_____ Birth State _____

4. Social Security # _____ - _____ - _____

5. Residential Address (City, State, Zip)
_____
_____

6. Tel. Home (_____) _____ - _____
Bus. (_____) _____ - _____
E-mail Address _____

7. Business Name & Address (City, State, Zip)
_____
_____

8. Amount of premium prepayment $ _____

9. Option Date _____ /_____ /_____

B Changes that *do not* Require Underwriting

1. Change Dividend Options to ☐ Cash ☐ Reduce Premium
Excludes Radius series

2. ☐ Change agency of record to _____
and servicing agent code to _____

3. New Address for Premium Notices (City, State, Zip)
_____
_____

4. ☐ Cancel the following riders _____
_____

5. AIR/AIB/AABI
- ☐ Cancel existing and future increases
- ☐ Retain existing increases and freeze future increases *(AIR only)*
- ☐ Decline current year's increase *(AIB/AABI only)*

6. ☐ Reduce basic monthly income to $ _____
- ☐ Reduce the following riders/agreements
  - a. _____ to $ _____
  - b. _____ to $ _____
  - c. _____ to $ _____

7. ☐ Increase Waiting Period to _____

8. ☐ Decrease Benefit Period to _____

9. ☐ Dividend Assignment
☐ Recipient of Benefits Assignment
Name (First, Middle, Last)
_____
Relationship _____
Residential Address (City, State, Zip)
_____
_____
Social Security # _____ - _____ - _____
Tax ID # _____ - _____ - _____

10. ☐ Lower AXIS accident pool amount
Details on Group LTD _____

11. ☐ Increase AXIS accident pool amount
- ☐ I no longer have Group LTD
- ☐ I am currently working at least 30 hours per week
- ☐ I have no other individual Disability Income coverage in force or applied for

12. Details *(Please reference question #)*
_____
_____
_____

C Occupational Data

Complete for all changes requiring medical and financial underwriting

Explain "Yes" answers in Details. Yes No

1. Are you currently disabled and/or collecting disability benefits? ☐ ☐

2. For the period of time beginning **90 days prior** to, and including, the date of this application:

a. have you been continuously at work on a full time basis (minimum 30 hours per week) performing all the duties of your occupation without limitation due to injury or sickness? ☐ ☐

b. have you been homebound or hospitalized due to injury or sickness? ☐ ☐

c. how many days have you missed due to an injury or sickness? ☐ ☐

Dates and Details for 2 (a), (b), and (c) _____

_____

3. Occupational Title and Duties _____

_____

4. Do you plan to change your occupation or hours worked? ☐ ☐

5. Dates and Details *(Please reference question #)* _____

_____

D Option Exercises, Conversions, Benefit Renewals, Occupational Class Changes

Complete Sections C and H, if applying for BOE coverage also complete Section J and for Buy-Sell complete Section I

Option Exercises

1. Exercise ☐ FIO Option ☐ GSR-FIO Option ☐ Buy-Sell FIO ☐ BOE FIO

Amount of additional FIO benefit $ _____ Amount of additional GSR-FIO benefit $ _____

1A. ☐ Special 5th Year amount (1x up to original base)

2. Exercise

DIPR/BIPR ☐ Additional Monthly Income Rider (AMIR/AMIA)

☐ Annually Renewable Disability Income Rider (ARDI)

☐ Contingent Monthly Income Rider (CMR)

☐ IMBR

Amount of additional benefits $ _____

Conversions

3. GSR Conversions

Date of termination with previous employer _____

Date LTD plan with present employee terminated _____ *(please include statement from HR)*

(Only eligible within 90 days after change or termination of Group LTD Plan)

Include telephone number(s) to conduct PHI_____

4. Conversions of ☐ AIR to _____ ☐ CMR to _____

☐ ARDI to _____ ☐ Other _____

Note: ARDI to AMIR complete Section C only

If the entire amount is not to be converted, the amount not being converted is to be ☐ Continued ☐ Terminated

Renewals

5. ☐ Renewal of coverage beyond age 65 Renewal date _____

6. ☐ Right to future increases under AIR Future increase date _____

7. ☐ AIB/AABI Renewal *(AABI subject to contract rules)*

Occupational Class Changes

8. ☐ Change Occupational Class to _____

E Changes Requiring Medical & Financial Underwriting

Complete Sections C, E, F, G, H and K, if applying for BOE coverage also complete Section J and for Buy-Sell complete Section I

1. ☐ Increase Benefit Period to _____

2. ☐ Decrease Waiting Period to _____

3. ☐ Addition of Rider Coverage

4. Other Benefits: *(Current Product Offering only)*

☐ Automatic Additional Benefit

☐ Catastrophic Disability Benefit
Monthly Benefit $ _____
Benefit Period ☐ 2 Year ☐ 5 Year ☐ 10 Year ☐ To Age 65 ☐ To Age 67
Waiting Period ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days ☐ 730 days

☐ Cost of Living

☐ Extended Partial (Waiting Period and Benefit Period must be same as base policy. Not available if Partial Rider is elected.)

☐ Partial Rider (6 month Benefit Period only. Waiting Period must be the same as base policy. Not available if Extended Partial is elected.)

☐ Own Occupation

☐ Future Insurability Option (FIO) $ _____
Option Month _____ (if different from Anniversary)

☐ Short Term
(1) Monthly Benefit $ _____
☐ 60 days Waiting Period/4 mos. Benefit Period
☐ 90 days Waiting Period/3 mos. Benefit Period
(2) Monthly Benefit $ _____
☐ 180 days Waiting Period/6 mos. Benefit Period

☐ Group Supplement (To Age 65 and To Age 67 Benefit Periods only. Waiting Period can be equal to or greater than base policy. If electing this Rider, the Extended Partial must also be elected.)
☐ A – Partial Monthly Benefit $ _____ Waiting Period _____
☐ B – Proportional* Monthly Benefit $ _____ Waiting Period _____
☐ Conversion Option*
*(Not available if Own Occupation Rider is elected.)

☐ HIV $ _____ (No Waiting Period. 24 months maximum Benefit Period)

☐ Managerial Duties Endorsement

5. RetireGuard Rider:
Monthly Benefit $ _____
Benefit Period ☐ 10 Year ☐ To Age 65 ☐ To Age 67
Waiting Period ☐ 180 days ☐ 365 days
☐ RetireGuard Future Insurability Option (FIO) $ _____
Option Month _____ (if different from Anniversary)
☐ RetireGuard Cost of Living Option (COLA)
Amount of Contribution $ _____ ☐ Annual ☐ Monthly
(Employer $ _____ Employee $ _____)

6. Recipient of Benefits Assignment for RetireGuard Rider:
Name (First, Middle, Last)
_____
Relationship _____
Social Security Number _____ - _____ - _____
Tax ID Number _____
Residential Address (City, State, Zip)
_____
_____

7. Other
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

F Changes Requiring Medical Underwriting

Complete Sections C, G and K

1. ☐ Reconsider Substandard Rating

2. ☐ Reconsider Exclusion Rider(s)

3. ☐ Non-smoker *(Home Office Specimen required)*

4. ☐ Other

5. Details _____
_____
_____
_____

G Evidence of Insurability

For each item checked "Yes," enter details in 5

Explain "Yes" answers in Details.

		Yes	No
1.	Do you plan any foreign travel or residence? *(If "Yes," submit supplement (F6290))*	☐	☐
2.	In the past 3 years have you taken part in, or do you now expect to take part in, underwater diving, hang gliding, para sailing, para kiting, parachuting, skydiving, mountain climbing, or organized racing by automobile, motorcycle, motorboat, or snowmobile or any other form(s) of hazardous activity? *(If "Yes," submit Avocation Supplement (A3320))*	☐	☐
3.	In the past 3 years have you been in a motor vehicle accident, been convicted of operating a motor vehicle while under the influence of alcohol or other drugs, been convicted of a moving violation or received a driver's license restriction, suspension, or revocation?	☐	☐
4.	In the last 10 years, have you applied for life or health insurance and been declined, postponed, rated or restricted? *(If "Yes," provide name of carrier, date and reason)*	☐	☐

5. Dates and Details _____

_____

_____

H Financial Data

1. Employment Status

☐ Employee (no ownership) ☐ Sole Proprietor ☐ Partner _____ % ownership

☐ S-Corporation Shareholder _____ % ownership ☐ C-Corporation Shareholder _____ % ownership

2. Earned Income (Business owners include share of business profit/loss in addition to wages)

Current year $ _____ Prior year $ _____

3. Unearned Income (ex: interest, dividends, capital gains, rents)

Current year $ _____ Prior year $ _____

4. Total Net Worth if 3 million dollars or more (assets minus liabilities) $ _____

5. Describe all Disability Income pending or in force coverage (If none, please answer "none".)

Type of Plan: Individual (I), Group (G), Buy-Sell (B), Association (A), Business Overhead (O)

Company	Type (I, G, B, A, O)	Issue Year	Monthly Amount	Benefit Period	Waiting Period	Employer Pay (Yes/No)	Is this being replaced?	Effective replacement date

6. Will the Employer continue Proposed Insured's salary or income if disabled? ☐ Yes ☐ No

If "Yes," amount per month $ _____ # of months _____

7. Premium will be paid by ☐ Insured ☐ Employer ☐ Employer paid and included in Employee's W-2

I Buy/Sell

	Current Fiscal Year Projection Ending ____ mo ____ yr	Most Recent Completed Fiscal Year Ending ____ mo ____ yr	Second Most Recent Completed Fiscal Year Ending ____ mo ____ yr
a. Owner's salaries			
b. Net Profit (loss)			
c. Assets			
d. Liabilities			

J BOE

Complete if applying for Business Overhead Expense Coverage

1. List the total current average monthly expenses of the business.

Rent	$ _____	Employee's Salaries (not including principals)	$ _____
Mortgage Interest Payment	$ _____	Cost of leasing equipment	$ _____
Utilities (gas, light, water)	$ _____	Depreciation	$ _____
Taxes on real estate	$ _____	Maintenance Service	$ _____
Accountant/Legal Fees	$ _____	Other	$ _____
Malpractice, property and Liability insurance	$ _____		$ _____
		A. Total Monthly Expenses	$ _____
Dues for professional societies	$ _____	**B.** Proposed Insured's percentage of business ownership	_____ %
Business subscriptions	$ _____		
Interest on Business Loans	$ _____	Share of Total Monthly Expenses (**A** x **B**)	$ _____
Telephone	$ _____		
		Professional Replacement	$ _____

K Nonmedical (Part 2)

If Paramed or Exam required submit form A50GE197 or appropriate state version

1. Height _____ Weight _____ lbs. If your weight changed by over 10 lb in the last year, indicate amount and reason _____

2. Name & Address of Personal Physician (City, State, Zip) _____

_____

Tel. (_____) _____ - _____ Date last seen and reason _____

3. Family History:

Relative	Health Problems — Include age at onset (especially for cardiovascular disease)	Age if Living	Age at Death	Cause of Death
Father				
Mother				
Brother(s)/Sister(s)				

Explain "Yes" answers in Details.	Yes	No
4. Have you:		
a. smoked cigarettes during the last 12 months?	☐	☐
b. used tobacco or products containing nicotine during the last 12 months?	☐	☐
c. used tobacco or products containing nicotine during the last 24 months?	☐	☐
5. In the last 10 years have you consulted a health professional regarding:		
a. chest pain, heart attack, high blood pressure, heart murmur, palpitations or any other disorder of the heart, arteries or veins?	☐	☐
b. a tumor or cancer including skin cancer, melanoma or colon polyps?	☐	☐
c. a disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia or lymphoma?	☐	☐
d. a disorder of your brain, spinal cord or nervous system including seizures, tremors, paralysis, dizziness, fainting, headaches, stroke or TIA (transient ischemic attack)?	☐	☐
e. depression, anxiety, nervousness, stress, psychosis, suicide thoughts or attempts, anorexia or bulimia, post traumatic stress disorder, obsessive compulsive disorder, bipolar disorder, or other emotional disorder?	☐	☐

K Nonmedical (continued)

If Paramed or Exam required submit form A50GE197 or appropriate state version

	Yes	No
6. In the last 10 years have you:		
a. used cocaine, barbiturates, narcotics, stimulants, hallucinogens or other controlled substances not prescribed by a physician?	☐	☐
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?	☐	☐
7. In the last 5 years have you consulted a health professional regarding:		
a. a disorder of your eyes, ears, nose, throat or sinuses including any partial or complete loss of hearing, vision or speech?	☐	☐
b. asthma, allergies, shortness of breath, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), pneumonia, sleep apnea, tuberculosis or any other disorder of your respiratory system?	☐	☐
c. a disorder of your digestive system, liver, pancreas or gall bladder including hepatitis, jaundice, ulcers, intestinal bleeding, colitis, Crohn's disease (ileitis), recurrent indigestion, diarrhea or diverticulitis?	☐	☐
d. a disorder or impairment of your muscles, bones, joints, nerves, spine, neck or back including arthritis, gout, sciatica or amputations?	☐	☐
e. Epstein-Barr virus, Lyme disease, chronic fatigue syndrome, fibromyalgia, lupus or other rheumatologic disorder?	☐	☐
f. diabetes or a disorder of your thyroid, pituitary or adrenal glands?	☐	☐
g. a disorder of your kidneys, bladder, prostate or urinary tract or findings of sugar, protein or blood in the urine?	☐	☐
h. a disorder of your uterus, cervix, ovaries or breasts?	☐	☐
i. multiple miscarriages, complicated pregnancy or infertility evaluation?	☐	☐
j. a disorder of your skin including eczema, psoriasis or latex allergy?	☐	☐
k. a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	☐	☐
8. In the last 5 years, have you:		
a. had an application for life, disability or health insurance declined, postponed, rated or restricted?	☐	☐
b. had a sickness or injury for which you made a disability claim or for which you received payments, benefits or pension benefits?	☐	☐
9. In the last 3 years, unless previously stated on this application, have you:		
a. had a physical exam, checkup or evaluation by a health professional?	☐	☐
b. had an injury treated by a health professional or medical facility?	☐	☐
c. had an electrocardiogram, x-ray, blood test or other diagnostic test, excluding an HIV test?	☐	☐
d. had surgery or been a patient in a hospital, clinic or other medical or mental health facility?	☐	☐
e. been advised to have surgery, medical treatment or diagnostic testing, excluding HIV testing, that has not been completed?	☐	☐
10. Are you currently:		
a. under treatment or taking any prescribed medication?	☐	☐
b. taking any herbal or non-prescription medication at least weekly?	☐	☐
c. pregnant? *(If "Yes," provide expected delivery date: _____)*	☐	☐

11. Remarks/Details:

_____

_____

_____

_____

_____

L Agreement and Signature

This is Part 1 of an application. The application includes any Part 2 that may be required and any amendments or supplements to either Part. This application shall be attached to and form a part of any policy of insurance issued. **Company, as used in this Application, refers to Massachusetts Mutual Life Insurance Company.**

Liability of Company – If a premium is accepted with this Application in exchange for a Conditional Receipt signed by the Agent, the Company's liability will be as stated in that Receipt. The Applicant also acknowledges receiving a copy of such Receipt.The new insurance, conversion, change, or renewal being applied for will not take effect unless each of the applicable conditions is met:

1. If this is an application for a Rider being purchased during an **Option Period under a Disability Income Purchase Rider/Business Insurability Protection Rider** than that Rider becomes effective as stated on the schedule page of the policy, but no earlier than the date the application for the Rider is signed if:
   - The first premium is paid to the Company on or within 60 days before the end of the Option Period; and
   - The application is approved by the Company at its Home Office.
2. If this Application is made in accordance with and subject to the provisions of the **Insurability Rider** contained in the above policy and the Date of Issue of the coverage applied for is within two years of the Date of Issue of that rider; the undersigned represent(s) that the statements and answers pertaining to the insurability of the proposed insured contained in the Application for that rider were as of its date true and complete to the best knowledge and belief of the undersigned.
3. If this is an application for any **other addition, or change,** any costs or first premium may be paid to the Company's agent in exchange for a Conditional Receipt signed by the agent. If not, the Company shall have no liability unless and until:
   - The application is approved by the Company at its Home Office; and
   - The first premium, or cost to change has been paid; and
   - At the time of payment, all statements in the application that relate to the insurability of the Insured are complete and true as though they were made at that time. However, if a later date is requested for an addition or change, the addition or change will not become effective until that later date.
4. If this is an application for **conversion of disability insurance,** the new coverage being applied for shall take effect as of the Issue Date shown in that policy only if:
   - All costs for the conversion, including but not limited to any required first premium for the coverage being applied for, less any conversion allowances, are paid to the Company; and
   - The application is approved by the Company at its Home Office.
5. If this is an application for **Renewal of Coverage after Age 65,** the renewal applied for will not become effective until this application is approved by the Company at its Home Office. If the renewal is approved, it will become effective on the Renewal Date. If a reduction in coverage is required, the renewal is contingent on an amendment executed by the Owner.
6. If this is an application for **Future Increases Under AIR/AIB/AABI,** the right to future increases applied for will not become effective until this application is approved by the Company at its Home Office. If approved, the right to future increases will become effective on the Future Increase Date.

Under no circumstances will the coverage being applied for provide coverage for disability beginning prior to the date of this application.

Authority of Agents – No agent can change the terms of this application or any policy issued by the Company. No agent can waive any of the Company's rights or requirements or extend the time for any payment.

Authorization to Obtain and Disclose Information (For the Insured and/or Owner) – I have received the Notice about the Medical Information Bureau, Inc.(MIB). I have also received the Summary of Consumer Rights. I understand and authorize an investigative report be made. This report may include information about my character, general reputation, personal characteristics, and mode of living. I hereby authorize certain parties that have any records or knowledge of me and my health to make such information available to Massachusetts Mutual Life Insurance Company or its reinsurers. These parties include: any licensed physician, medical practitioner, hospital, clinic, other medical or medical related facility, insurance company, the MIB, or other organization. This release shall be valid for 30 months from its date. I agree that a photocopy or facsimile of this authorization may be used to obtain information.

The person(s) signing below agree that, to the best of their knowledge and belief, all statements in this application are complete and true and were correctly recorded. They also adopt all statements made in the application. Under penalty of perjury, the Owner certifies that the Social Security number shown on this application is correct and that he/she is not subject to back up withholding.

ANY POLICY ISSUED AS A RESULT OF A MATERIAL MISSTATEMENT OR OMISSION OF FACTS MAY BE VOID, AND THE COMPANY'S ONLY OBLIGATION SHALL BE TO RETURN PREMIUMS PAID.

X _____ **X** _____

Signature of Proposed Insured | Signature of Owner *(If not the Proposed Insured)*

Signed at _____ on _____

City and State | Date

X _____

Licensed Agent *(Signature required where applicable)*

Agent's Certificate

I/We declare and agree:
1. The answers to the above questions are true to my/our best knowledge; and
2. I/We are properly licensed to solicit this application; and
3. The undersigned are the sole parties entitled to commissions.

SIGNATURE OF SOLICITING AGENT

X _____

☐ **F**ULL-TIME ☐ **A**OC
☐ **P**ART-TIME ☐ **S**INGLE CASE AGREEMENT
☐ **B**ROKER

Type or print above name here and name of company if applicable

1st YR SHARE % REN'L SHARE %

ASSISTING AGENT'S SIGNATURE (IF ANY)

X _____

☐ **F**ULL-TIME ☐ **A**OC
☐ **P**ART-TIME ☐ **S**INGLE CASE AGREEMENT
☐ **B**ROKER

Type or print above name here and name of company if applicable

1st YR SHARE % REN'L SHARE %

Agency No General Agent

For Agent's Plate(s)

Agent's Certificate

I/We declare and agree:
1. The answers to the above questions are true to my/our best knowledge; and
2. I/We are properly licensed to solicit this application; and
3. The undersigned are the sole parties entitled to commissions.

SIGNATURE OF SOLICITING AGENT

X _____

☐ **F**ULL-TIME ☐ **A**OC
☐ **P**ART-TIME ☐ **S**INGLE CASE AGREEMENT
☐ **B**ROKER

Type or print above name here and name of company if applicable

1st YR SHARE % REN'L SHARE %

ASSISTING AGENT'S SIGNATURE (IF ANY)

X _____

☐ **F**ULL-TIME ☐ **A**OC
☐ **P**ART-TIME ☐ **S**INGLE CASE AGREEMENT
☐ **B**ROKER

Type or print above name here and name of company if applicable

1st YR SHARE % REN'L SHARE %

Agency No General Agent

For Agent's Plate(s)

Agent's Certificate

I/We declare and agree:
1. The answers to the above questions are true to my/our best knowledge; and
2. I/We are properly licensed to solicit this application; and
3. The undersigned are the sole parties entitled to commissions.

SIGNATURE OF SOLICITING AGENT

X _____

☐ **F**ULL-TIME ☐ **A**OC
☐ **P**ART-TIME ☐ **S**INGLE CASE AGREEMENT
☐ **B**ROKER

Type or print above name here and name of company if applicable

1st YR SHARE % REN'L SHARE %

ASSISTING AGENT'S SIGNATURE (IF ANY)

X _____

☐ **F**ULL-TIME ☐ **A**OC
☐ **P**ART-TIME ☐ **S**INGLE CASE AGREEMENT
☐ **B**ROKER

Type or print above name here and name of company if applicable

1st YR SHARE % REN'L SHARE %

Agency No General Agent

For Agent's Plate(s)

MassMutual FINANCIAL GROUP®

Massachusetts Mutual Life Insurance Company
1295 State Street, Springfield, MA 01111-0001

HIPAA Authorization

For use with Life, DI and 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.

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.

B Agreements, Understandings & 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 Department, 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.
- A copy or facsimile of this Authorization is valid as the original.
- This authorization is valid for twenty-four (24) months from the date I sign it.
- I 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 of Insured/Representative: _____

Printed name: _____ Date: _____

Date of birth *(mm/dd/yyyy):* _____

Relationship to 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 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 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 or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant 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 anitbodies, 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.

This Authorization complies with HIPAA Privacy Rule.
"HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended.

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.

B Agreements, Understandings and 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 Department, 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.
- A copy or facsimile of this Authorization is valid as the original.
- This authorization is valid for twenty-four (24) months from the date I sign it.
- I 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 of Insured/Representative: _____

Printed name: _____ Date: _____

Date of birth *(mm/dd/yyyy):* _____

Relationship to 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 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 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 or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant 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 anitbodies, 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.

Important Health Information

Michigan Department of Community Health MDCH
Jennifer M. Granholm, Governor
Janet Olszewski, Director

MDCH is an Equal Opportunity Employer, Services and Programs Provider.

Michigan Department of Community Health
DCH-0675 (formerly HP-143)
Authority: P.A. 368/1978
(Revised 4/04)

Table of Contents ***Page***

Human Immunodeficiency Virus (HIV) Antibody Test Information Booklet

Consent Form for the Human Immunodeficiency Virus (HIV) Antibody Test

To be completed before blood draw and submitted with application.

NOTE: At the time HIV Consent form is signed, the Information Booklet is required to be left with the client.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST INFORMATION BOOKLET

Q: What is an HIV Test?

A: Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS).

Laboratory tests tell whether you have been infected with HIV. A test is not considered positive unless a different backup test is done and also reads positive. These tests are conducted on a single sample of your blood or on an oral sample from your mouth or on a urine sample. Test results may, on rare occasions, be inconclusive, and this possibility should be discussed with your health professional.

Q: Will the HIV test tell me if I have AIDS?

A: No. A positive test means you have become infected with the virus. While some people infected with the virus have gone on to develop AIDS, others have not yet developed AIDS. Healthy lifestyle and behavior changes, improved diet, and, most importantly, early medical treatment may help you delay, or avoid, the development of AIDS.

Q: How long after exposure does it take to tell if I am infected?

A: Most people will test positive within three months after exposure. The average time is less than one month. However, a few people have taken up to six months or even one year to test positive.

Q: How does a person become infected with HIV?

A: The virus is most commonly spread through sexual contact (vaginal, anal, or oral sex) and by sharing needles or works to shoot injectable drugs. An infected mother may infect her baby during pregnancy, at the time of birth, or while breast feeding. Very rarely, contact with blood through open cuts or wounds, or splashes to the eyes, may also spread the virus. **You cannot get infected with the virus by donating or giving blood, or through casual contact.**

Q: Do I have to have this test?

A: Generally, getting tested is your decision. In Michigan, testing is required if you are a potential organ, semen, tissue, or blood donor; a military recruit; an immigrant; or if you have been charged and bound over, or convicted of certain crimes in a court of law. In addition, some health care facilities may have an admission requirement that you consent to be tested if a health care worker is accidentally exposed to your blood during your stay in their facility.

An insurance company has the right to request that you take an HIV test if you apply for new health or life insurance. If you refuse or if you test positive, as with any other potentially serious health condition, you will probably be turned down for this new insurance.

Q: Who should consider having the HIV test?

A: The Michigan Department of Community Health recommends that HIV testing be considered by anyone who meets any of the following:

- People who have had a sexually transmitted disease (venereal disease).
- People who have shared needles or who have a history of drug abuse.
- Men who have had sex with other men.
- Men or women who have had unprotected sex with anyone whose HIV status is unknown. (Unprotected sex means there has been an exchange of semen or vaginal secretions between the partners.)
- People who have had more than one sex partner.
- People who have had sex with prostitutes (male or female).
- People who received blood products or blood transfusions between 1978 and 1985.
- People who exchange sex for drugs or money.
- People who are infected with tuberculosis.
- People who have had exposure to the blood of someone who may be infected.
- People who have had sex with any person from the above list, particularly with injecting drug users.
- **Women who are pregnant or who are considering pregnancy.**
- Women who are diagnosed with invasive cervical cancer.

Q: Where can I have the test done without my name being used?

A: All local health departments and other testing centers designated by the Michigan Department of Community Health will provide the option to you to be tested with your name (confidential testing) or without your name (anonymous testing). Any person giving you this test is required by law to keep your test results confidential, with a few exceptions specified by law. If you request testing without your name, these facilities have trained counselors who will counsel you on an anonymous basis. If anonymous testing is done and you have a positive test, you need to know that health care and treatment are not provided on an anonymous basis.

Q: Who will know the results of my test?

A: Any person giving you this test is required by law to keep your test results confidential. Even the courts must follow specific rules before they can require disclosure through a court order. A subpoena is not sufficient to require disclosure; you will be asked to sign a separate release form. If this information needs to be released beyond the requirements of the law, you will be asked to sign a separate release form.

In Michigan, positive test results are reportable to the state and local health departments. The health department will maintain your confidentiality and use this information to understand the extent of infection in Michigan's communities. This information may also be used by your health provider or local health department as needed to properly diagnose and care for you and protect your health, to assist you in notifying your sexual or needle-sharing partners, and to prevent spread of the virus. The test results, if positive, will also be given to a potential spouse if you are planning to get married. If you are a health care worker, you should be aware of state guidelines regarding infected health care workers.

If you are tested in a physician's private practice office, or in the office of a physician affiliated with or under contract with a Health Maintenance Organization, you may request that your name, address, and phone number not be included in the HIV-positive report to your local health department. It is against the law in Michigan for local health departments to keep lists of names of infected people.

Michigan law now requires that, if you are infected, your physician or the local health officer must warn (notify) all of your known sexual or needle-sharing partners of the fact that they have been exposed. In doing this, they are required to keep your identity confidential.

Q: Are there any risks involved in having the test done?

A: There are three ways you can be tested for HIV. They are by drawing a sample of blood, taking an oral sample from your mouth, or testing your urine.

There are virtually no medical risks in drawing a small sample of blood. Only sterile needles and syringes are used for this purpose. Once the needle or syringe is used, it is safely thrown away or properly sterilized. If an oral sample from the mouth is used for the test, a specially-treated pad is placed between the lower cheek and gum and held for two minutes. This causes no risk or pain. The urine test requires only a urine sample.

Before you are tested, you should carefully think about to whom you would tell the results, and what emotional support systems are available to you. The Michigan Civil Rights Commission has ruled that AIDS, HIV infection, and the suspicion of AIDS or HIV infection are considered handicapping conditions. Therefore, people are not to be discriminated against, and have all the rights of a handicapped person as defined under the Michigan Persons with Disabilities Civil Rights Act, PA 220 of 1976 (formerly, the Michigan Handicappers' Civil Rights Act). Federal laws make similar rulings through the federal Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. The Americans with Disabilities Act of 1990 strictly forbids discrimination against persons with HIV or AIDS.

Q: What will happen to the consent form after I sign it?

A: If you decide to be tested, you will be asked to sign a consent form. If you test anonymously, you can sign using a number or a fake name. Procedures for filing the consent form will vary from facility to facility. Please ask your health professional if you would like to know what their confidentiality procedure is.

Q: Can I change my mind after I sign the consent form?

A: Yes, you can change your mind at any time before the laboratory performs the test. If you change your mind, you will have to provide a written request that the test not be done to the person or organization providing you with this information booklet.

Q: How will this test help me?

A: If you are tested, you most likely will be required to appear in person to get your test results. Whether your results are positive or negative, your overall health may be helped from discussions with your health professional.

If you test negative, the test indicates either that you are not infected, or possibly, that you were infected very recently (within the past 3-6 months). You can learn through counseling how to protect yourself from infection in the future. If you have recently practiced risky behavior, you may want to be retested.

If you test positive, the test indicates that you have been infected with HIV. You can still take action to benefit your health and **reduce the chance of infecting others.** This includes maintaining a good state of physical and mental health. By doing so, you may delay the development of AIDS. It is suggested that you:

- Seek medical treatment immediately. Many drugs are now available for treatment of persons infected with HIV even if symptoms are not present. Early treatment is usually beneficial to many people with HIV.
- Receive all recommended vaccines. Discuss with your physician which vaccines are recommended and which should be avoided.
- Maintain good nutrition, exercise and get adequate rest.
- Receive emotional support and work on managing stress.
- Eliminate recreational drugs, or at least reduce alcohol and smoking.
- Stop injecting drugs. If you continue to inject, stop sharing equipment, and use a new syringe and needle each time. At the very least, you should learn to clean your needles or works with full-strength bleach and water.
- Don't have vaginal, anal, oral or other sexual contact that exposes others to your semen, vaginal secretions or blood. Avoid exposing others and getting sexually-transmitted diseases (through abstinence or by always using latex or polyurethane condoms or barriers).
- Inform all known sexual or needle-sharing partners including new partners about your infection.
- Do not donate blood or organs (change designation on driver's license).
- Seek counseling regarding becoming pregnant or fathering a child.
- If you are pregnant and planning to continue that pregnancy, discuss with your physician treatments that may protect your baby.

Q: Whom should I tell if I am HIV-positive?

A: If you test positive, you need to know that this infection is not passed to another person through casual contact. Michigan law requires that you must notify any new sexual partner prior to having sex with them. Past sexual and needle-sharing partners are to be notified so that they can also be counseled and offered testing. If requested, your local health department will provide you assistance in notifying partners.

Inform all health care providers, both medical and dental, who are providing you treatment, about your HIV infection. This will help them care for you.

The law prohibits health care providers from refusing to treat you based upon your HIV infection.

New guidelines indicate that HIV-infected pregnant women should undergo treatment for HIV disease. This treatment may reduce the risk of transmission to the newborn by 60 - 70%.

Finally, be careful about discussing your HIV status with others. Some people may not understand the nature of the infection or how it is actually spread. This may lead to misunderstanding and create problems for you with friends, co-workers, or others.

Q: What if I have more questions?

A: Please ask the health professional who gave you this booklet. Your health professional will have the answers to your questions or will get the answers for you. You should feel free to call the statewide AIDS information hotline (1-800-872-AIDS; Spanish 1-800-862-SIDA; TDD 1-800-332-0849) or your local health department at any time if you have questions or need help.

MassMutual FINANCIAL GROUP℠

CONSENT FORM FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

I have been informed that my blood, an oral sample from my mouth, or my urine will be tested for antibodies to the Human Immunodeficiency Virus (HIV), the virus that causes AIDS.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results.

I have been informed that the HIV test results are confidential and shall not be released without my written permission, except to

_____

Name of the physician or health facility who will receive the HIV test results.

_____

Street Address

_____, and as permitted under state law.

City State Zip

I understand that I have a right to have this test done without the use of my name. If my private physician does not provide anonymous testing, I understand I may obtain anonymous testing at a Michigan Department of Community Health-approved HIV counseling and testing site.

I understand that I have the right to withdraw my consent for the test at any time before the test is complete.

I acknowledge that I have been given a copy of the booklet *Important Health Information.* I have been given the opportunity to ask questions concerning the test for HIV antibodies, and I acknowledge that my questions have been answered to my satisfaction.

I understand that I will receive a copy of this consent form upon request.

Agreements and Signatures

By my signature below, I consent to be tested for HIV.

X_____ _____

Signature of Proposed Insured - (Signature of Parent or Guardian if Proposed Insured is under age 16) Date

X_____ _____

Signature of Witness Date

AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS

X_____ _____

Signature of Proposed Insured - (Signature of Parent or Guardian if Proposed Insured is under age 16) Date

X_____ _____

Signature of Witness Date

MassMutual FINANCIAL GROUP™

Disclosure Statement About Our Policy's Premium Payment Options

Please Read This Information Carefully

As a policyholder of MassMutual, you have the right to choose among four payment plan options for paying your annual premium. Each payment option, other than annual, costs more mone y. Among our policyholders, the additional cost varies depending upon the type of polic y and its original issue date. A generic description of the payment options and range of costs, e xpressed as dollars and as annual percentage rates, are described below.

Premium Payment Options

You may pay premiums once a year (annually), twice a year (semi-annually), or four times a year (quarterly) or twelve times a year (monthly).

If you pay your annual premium by installments, there will be an additional char ge.

a. If you pay semi-annually, the additional charge equals an annual percentage rate (APR) in the range of 8.2% to 18%. This would amount to an additional annual char ge in the range of $20 to $43 on an annual premium of $1,000.

b. If you pay quarterly, the additional charge equals an annual percentage rate (APR) in the range of 2.4% to 23.7%. This would amount to an additional annual char ge in the range of $9 to $88 on an annual premium of $1,000.

c. If you pay monthly, the additional charge equals an annual percentage rate (APR) in the range of 4.3% to 22.1%. This would amount to an additional annual char ge in the range of $20 to $103 on an annual premium of $1,000.

There may be other premium payment options a vailable on certain products. Please contact MassMutual at 1-800-272-2216 for more information.

If you would like to know the exact dollar amount of the additional char ge or the Annual Percentage Rate that you are paying because you pay your annual premium in installments, you may access our "Modal Charge Disclosure and Annual Percentage Calculator" link at www .massmutual.com/calculators and follow the simple instructions. Alternatively, you may call this toll free number 1-800-272-2216 and we will provide you with the information.

How To Change Your Premium Payment Option*

You also have the right to change this option during the lifetime of your polic y. In order to make a change, you must either:

- Inform your MassMutual agent that you wish to change the premium payment frequenc y for your policy; or
- Notify MassMutual in writing via regular mail (MassMutual Financial Group Customer Service Hub at 1295 State Street, Springfield, MA 01111-0001) or contact us at www .massmutual.com that you wish to change the premium payment frequency for your policy's premium. To request a change in your policy's premium payment frequency, be sure to include the polic y number in your correspondence; or
- Contact a MassMutual Customer Service Representati ve at 1-800-272-2216 and inform the representative that you wish to change the premium payment frequenc y for your policy.

* If your premium is paid through a payroll deduction, there may be limitations on your ability to change the payment option. Contact your MassMutual agent to determine if your premium payment option can be changed.

This notice does not change any of the terms of your MassMutual policy.

MassMutual FINANCIAL GROUP®

Important Privacy and Consumer Information

Privacy Notice

At MassMutual, we recognize that our relationships with you are based on integrity and trust. As part of that trust relationship, we are committed to keeping your personal information private. We also want you to be aware of how we protect, collect and disclose your personal information.

We protect your personal information by:

- Maintaining physical, electronic and procedural safeguards to protect your personal information;
- Restricting access to your personal information to employees with a business need to know;
- Requiring that any MassMutual business partners with whom we share your personal information protect it and use it exclusively for the purpose for which it was shared;
- Ensuring personal information is only shared with third parties as necessary for standard business purposes or as authorized by you; and
- Ensuring medical and health information is only shared with third parties to perform business, professional or insurance functions on our behalf or as authorized by you.

We may collect personal information about you from:

- Our interactions with you, including applications and other forms, interviews, communications and visits to our website;
- Your transactions with us or our affiliated companies; and
- Information we obtain from third parties such as consumer or other reporting agencies and medical or health care providers.

We may share personal information about you 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;
- 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 account or policy;
- Courts and government agencies in response to court orders or legal investigations;
- Credit bureau reports; and
- Other financial institutions with whom we may jointly market products, if permitted in your state.

Consistent with our commitments stated above, please know that if any sharing of your personal information will require us to give you the option to opt-out of or opt-in to the information sharing, we will provide you with this option.

MassMutual Financial Group is a marketing name for Massachusetts Mutual Life Insurance Company (MassMutual) and its affiliated companies and sales representatives. This notice is provided by the following companies in the MassMutual Financial Group:

- Massachusetts Mutual Life Insurance Company
- MML Investors Services
- C.M. Life Insurance Company
- MML Bay State Life Insurance Company

For more information regarding MassMutual's privacy and security practices, please visit www.massmutual.com.

Please note: Customers with multiple MassMutual products may receive more than one copy of this notice.

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 associate. 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 (TTY 866-346-3642). 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 federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 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.

MassMutual Financial Group is a marketing designation (or fleet name) for Massachusetts Mutual Life Insurance Company (MassMutual) and its affiliates.