Colorado

Employer Sponsored Application Packet for SignatureCare® Insurance
500 Policy Series

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MassMutual FINANCIAL GROUP℠

We'll help you get there.℠

Massachusetts Mutual Life Insurance Company

Long Term Care Insurance

LTCNBSA-CO 1110

Long-Term Care Insurance Application Forms for Signature Care® 500 (Simplified Application)

COLORADO

November 1, 2010

This replaces Application Instructions MM500Ref-SA-AI-CO, and has been updated to reflect revised forms due to the state requirement that an "agent" must be referred to as an "insurance producer."

IMPORTANT REMINDERS BEFORE YOU TAKE AN APPLICATION

- State regulations require producers to meet licensure and applicable presale training requirements (where required) otherwise producers must not attempt to solicit, negotiate or sell long term care insurance. Requirements vary by state.
- Initially Quote Select Preferred rate class. NOTE: Final rate class will be based on the results of underwriting.
- Provide "The Long Term Care Underwriting Process" **(LTC4511)** to your clients to prepare them for the underwriting process.
- Review Suitability Standards and Rate Stabilization with the applicant(s).
- Prior to completing application, leave the "Shopper's Guide to Long Term Care Insurance" **(LTC2100)** with the applicant(s).
- Outline of Coverage must be left with applicant(s).
- The application and all required forms must be complete and submitted to the LTC Administrative Office within 30 days of the application signed date.
- The application and all required forms MUST BE signed and dated where required and in all appropriate parts. **Incomplete applications result in processing delays.**
- Current date the application. The Policy Effective Date is the Underwriting Approval Date unless the application indicates to save age. To save age (we will backdate up to 60 days), request this in the *Special Request* section under Section 3 of the application.
- Do NOT submit initial premium with the application.

STATE VARIATIONS

- Partnership policies are available.
- Suitability Standards and Rate Stabilization apply. Complete the LTC Insurance Personal Worksheet. See *Guidelines Regarding Suitability Standards for LTC Insurance* located on page 3.

APPLICATION and OTHER REQUIRED FORMS & DISCLOSURES

Copy to Each Applicant	Copy to LTC Admin Office	
No	Yes	New Business Transmittal **(MM-0109-4)**
No	Yes	Long Term Care Insurance Application **(MM500-SAP-1-1-CO)**
Yes	Yes	Long Term Care Insurance Personal Worksheet **(MM500-WRK-CO)**
Yes	Yes	HIPAA Authorization/Personal Health-Related Information **(F8186CO 0210)**
Yes	No	Complete the Outline of Coverage **(MM500-OOC-1-CO** or **MM501-OOC-1-CO) NOTE: the completed Outline of Coverage will print along with the illustration.**
Yes	No	Important Notice to Persons on Medicare **(MM-0166)**
Yes	No	Notice of HIPAA Privacy Practices **(LTC2039 0210)**

Yes	No	Disclosure Statement About Our Policy's Premium Payment Options **(COR4565a 1004)**
Yes	No	Things You Should Know Before You Buy Long-Term Care Insurance **(MM-N-LTC-CO)**
Yes	No	Long Term Care Insurance Potential Rate Increase Disclosure **(MM-N-PRI-LP)**
Yes	No	Important Privacy and Consumer Information **(N2000)**

OPTIONAL FORMS & DISCLOSURES YOU MAY NEED FOR SPECIAL SITUATIONS		
Copy to Each Applicant	Copy to LTC Admin Office	
Yes	Yes	Supplemental Application for Policy Ownership **(MM500-AO-1-CO)**
Yes	Yes	Notice to Applicant Regarding Replacement **(MM-0116-B-2-CO 0907)**
Yes	Yes	Automatic Payment Authorization **(F6445 706)**. Submit first copy with voided check.
Yes	Yes	Loyal Customer Discount Disclosure **(MMD-LCD-CO)**
Yes	Yes	Limited Premium Payment Option Disclosure **(MMD-LTD-CO)**
Yes	Yes	Discounted Renewals Premium Payment Option Disclosure **(MMD-DRP-CO)**. **Only available with Lifetime Premium Payment Option**
Yes	Yes	Adverse Underwriting Decision Release **(MM500AUD)**

OTHER IMPORTANT REMINDERS CHECKLIST

☐Attach applicable Illustration to the application.
☐Confirm applicant signed in their resident state, if partnership.
☐Confirm the applicant(s) answered "NO" to all questions in the Insurability Information (Section 2). If any question is answered "YES" it is suggested that you do not submit the application.
☐Consult Field Underwriting Guide **(LTC 50900S)** or Producer Reference Manual **(LTC50900 0710)** to confirm eligibility.
☐Provide the applicant(s) with all required forms and notices as noted above.
☐Attach Cover Letter (OPTIONAL) to explain any additional information that you may have regarding the applications to the underwriter.

GUIDELINES REGARDING SUITABILITY STANDARDS FOR LTC INSURANCE

State law requires both the insurance producer and the Company to assist the applicant in determining the suitability of a potential purchase of long-term care insurance. It is therefore very important that you read, understand, and implement the procedures outlined in this instruction. It will allow you to determine that your sale will meet the required suitability standards.

There are two additional forms that are required for each sale:

1. The first form is **MM-N-LTC-CO** and is titled "Things You Should Know Before You Buy Long-Term Care Insurance." You must review this form with each applicant and it should help you finalize the sale.
2. The second form is **MM500-WRK-CO**, "Long-Term Care Insurance Personal Worksheet." This worksheet must be filled out by the applicant with your assistance.

   The first section - Premium Information, requires you to complete the policy form number and fill in the anticipated premium. Point out the policy's renewability provision to the applicant and the possibility of a future rate increase.

   The second section - Questions Related To Your Income, requires you to check a box in each of two lines. In the first line of this section, the source of premium payments needs to be indicated. In the second line of this section, affordability of the policy needs to be indicated.

   The third section - What Is Your Annual Income? Requires you to check a box in each of two lines. In the first line of this section, the annual income of the applicant needs to be indicated. In the second line of this section, the expectation for change in income needs to be indicated.

      This section also requires you to analyze the applicant's ability to afford the premiums based on income. To do this, you must multiply the applicant's income by 7% (0.07). If this amount is less than the annual premium, then either family members must be paying the premium or savings must be the premium source with assets from the next section in the "Over $50,000" bracket. Otherwise, the proposed sale does not meet the suitability standards.

   The fourth section - Will You Buy Inflation Protection? Requires you to answer "Yes" or "No" and explain the difference between future costs and the daily benefit selected.

   The fifth section - What Elimination Period Are You Considering? Requires you to indicate the number of days, approximate cost for that period of care and discuss how the applicant plans to pay for this care.

   The sixth section - Questions Related To Your Savings and Investments. The first line of this section requires you to check a box indicating the value of the applicant's assets (excluding the applicant's home) and the next line requires the applicant to indicate the expected change in these assets. If the assets are less than $30,000, the sale does not meet suitability standards.

   The seventh section - Comparison to Current Coverage. If the insured has current coverage you are replacing, you must analyze the insured's current coverage and indicate (by checking the appropriate box) why the replacement is suitable. In addition, the premium for the applicant's existing coverage must be entered on the line provided.

   The eighth section - Disclosure Statement, requires the applicant to certify that the answers in the worksheet are accurate, or that the applicant declines to provide the financial information. It also requires the applicant to acknowledge that you have reviewed the form with them and that the applicant understands that premium rates may be increased in the future. **Authorization to Process Application**, must be signed if the applicant declines to provide the financial information.

We will send a letter if we determine that the proposed purchase may not be suitable for the applicant. If a letter is sent, the applicant must respond again within 60 days, or we will not underwrite the coverage and the file will be closed.

The next part of this section requires the insurance producer to certify that the importance of this form has been properly explained to the applicant.

The last part of this section **must** be completed if the applicant's proposed purchase does not meet suitability standards. The applicant will have to provide a compelling reason for the company to consider the risk if the applicant does not meet the required suitability standards.

SUMMARY - In general, the purchase of a long-term care policy will not be considered suitable if:

- Premiums for the proposed policy are more than 7% of applicant's income, unless the applicant's assets are greater than $50,000 or another premium source (such as family members) is indicated; or
- Applicant's assets (savings and investments) are under $30,000.

New Business Transmittal

Applicant Information (Please list applicants alphabetically by last name)			**Submitted Premium**	
First Name, Initial, Last Name	Age	HOME OFFICE USE ONLY	Mode	Collected

Agent and Agency Information		**Note: All splits must be whole numbers**	
Writing Agent Name:	Agent Number:	% FYC Split / % Renewal	Date:
Phone Number:	E-mail Address:		Agency:
Second Agent Name:	Agent Number:	% FYC Split / % Renewal	Date:
Phone Number:	E-mail Address:		Agency:
Third Agent Name:	Agent Number:	% FYC Split / % Renewal	Date:
Phone Number:	E-mail Address:		Agency:

Note: Policy splits are limited to three Agents.

Direct any communication regarding this case to:	Submitting Agency Name:	Date:
How would you prefer to be contacted? ❍ E-mail ❍ Telephone		
Contact's Phone Number:	Contact's E-mail Address:	Agency Number:

If the sale of this policy will be credited to more than one agency, specify below: **(Note: This is limited to two Agencies)**

Agency Name:	**Agency Number:**	**% FYC Split:**	**% Renewal**

If a Career Corporation, please list Sub-Agent splits below: **(Note: Splits must equal 100%)**

Agency Name:	**Agency Number:**	**% FYC Split:**

ATTACH PREMIUM CHECK HERE

Note: We do not accept Agent/Agency checks or COD business

THANK YOU FOR YOUR BUSINESS

Massachusetts Mutual Life Insurance Company
Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

LONG TERM CARE INSURANCE APPLICATION
MM500-SAP-1-1-CO Part 1 (PLEASE PRINT)

Coverage Type ☐ Individual ☐ (1 Partner Applying) ☐ (Both Partners Applying)

SECTION 1: PROPOSED APPLICANT PERSONAL INFORMATION

Proposed Applicant 1		**Proposed Applicant 2**	
Name (First) (MI) (Last)	Gender ☐ Male ☐ Female	Name (First) (MI) (Last)	Gender ☐ Male ☐ Female
Home Address (Street)(City) (State)(ZIP)		Home Address (Street)(City) (State)(ZIP)	
Billing Address (if different)		Billing Address (if different)	
Phone Home ( ) Work ( ) Best time to call? am or pm / home or work		Phone Home ( ) Work ( ) Best time to call? am or pm / home or work	
SS No.	Birth Date	SS No.	Birth Date
State of Birth		State of Birth	
Driver's License No.	License State	Driver's License No.	License State
Email (OPTIONAL):		Email (OPTIONAL):	
Occupation:		Occupation:	

SECTION 2: INSURABILITY INFORMATION

Proposed Applicant 1	**Proposed Applicant 2**
1. Do you currently need assistance with bathing, dressing, eating, taking medication, transferring from bed to chair or toileting? ☐ Yes ☐ No	1. Do you currently need assistance with bathing, dressing, eating, taking medication, transferring from bed to chair or toileting? ☐ Yes ☐ No
2. During the past 10 years, have you been medically diagnosed or treated for any of the following:	2. During the past 10 years, have you been medically diagnosed or treated for any of the following:
AIDS or positive HIV status ☐ Yes ☐ No	AIDS or positive HIV status ☐ Yes ☐ No
Alzheimer's Disease, Dementia ☐ Yes ☐ No	Alzheimer's Disease, Dementia ☐ Yes ☐ No
Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease ☐ Yes ☐ No	Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease ☐ Yes ☐ No
Cerebral Palsy ☐ Yes ☐ No	Cerebral Palsy ☐ Yes ☐ No
Cystic Fibrosis ☐ Yes ☐ No	Cystic Fibrosis ☐ Yes ☐ No
Hepatitis-Chronic ☐ Yes ☐ No	Hepatitis-Chronic ☐ Yes ☐ No
Huntington's Chorea ☐ Yes ☐ No	Huntington's Chorea ☐ Yes ☐ No
Insulin Dependent Diabetes ☐ Yes ☐ No	Insulin Dependent Diabetes ☐ Yes ☐ No
Kidney Disease requiring dialysis ☐ Yes ☐ No	Kidney Disease requiring dialysis ☐ Yes ☐ No
Liver Cirrhosis ☐ Yes ☐ No	Liver Cirrhosis ☐ Yes ☐ No
Multiple Sclerosis ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No
Myasthenia Gravis ☐ Yes ☐ No	Myasthenia Gravis ☐ Yes ☐ No
Organic Brain Syndrome ☐ Yes ☐ No	Organic Brain Syndrome ☐ Yes ☐ No
Paralysis ☐ Yes ☐ No	Paralysis ☐ Yes ☐ No
Parkinson's /Parkinsonism ☐ Yes ☐ No	Parkinson's /Parkinsonism ☐ Yes ☐ No
Schizophrenia ☐ Yes ☐ No	Schizophrenia ☐ Yes ☐ No
Stroke, TIA ☐ Yes ☐ No	Stroke, TIA ☐ Yes ☐ No
Systemic Lupus ☐ Yes ☐ No	Systemic Lupus ☐ Yes ☐ No

PLEASE NOTE: Before you continue with this application: If you answered YES to any of the questions under INSURABILITY INFORMATION above, we suggest you do not submit the application. If you answered NO to every question, please continue.

SECTION 2: INSURABILITY INFORMATION (continued)

PRIMARY CARE PHYSICIAN (PCP)

Proposed Applicant 1	**Proposed Applicant 2**
3. PCP (current) or MD who has the most complete records of your medical history. If you changed doctors in the past 12 months, please provide the previous doctor's information also. (medical records may be ordered)	3. PCP (current) or MD who has the most complete records of your medical history. If you changed doctors in the past 12 months, please provide the previous doctor's information also. (medical records may be ordered)
Name:_____	Name:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone: (____)_____	Phone: (____)_____
Date/Reason for Last visit:_____	Date/Reason for Last visit:_____
Medication(s) prescribed:_____	Medication(s) prescribed:_____

SECTION 3: COVERAGE AND PREMIUM INFORMATION

* If a PARTNERSHIP POLICY is selected below and You are age **60 or younger**, 5% Compound Inflation Protection must be selected and will be issued with Your Policy. If You are age **61-75**, either 5% Compound Inflation Protection, 3% Compound Inflation Protection or 5% Simple Inflation Protection must be selected and will be issued with Your Policy.

Proposed Applicant 1	**Proposed Applicant 2**
1. Basic Plan Selection ☐ Partnership Policy ☐ Non-Partnership Policy ☐ Facility Services Only ☐ Comprehensive (Facility Services and Home & Community Based Services (HCBS)) ☐ Comprehensive with Indemnity Benefit Rider ☐ Comprehensive with HCBS Monthly Benefit Rider	**1. Basic Plan Selection** ☐ Partnership Policy ☐ Non-Partnership Policy ☐ Facility Services Only ☐ Comprehensive (Facility Services and Home & Community Based Services (HCBS)) ☐ Comprehensive with Indemnity Benefit Rider ☐ Comprehensive with HCBS Monthly Benefit Rider
2. Daily Benefit Amount (DBA) $ _____	**2. Daily Benefit Amount (DBA) $** _____
3. Benefit Period ☐ Lifetime ☐ 10 Years ☐ 6 Years ☐ 5 Years ☐ 4 Years ☐ 3 Years ☐ 2 Years	**3. Benefit Period** ☐ Lifetime ☐ 10 Years ☐ 6 Years ☐ 5 Years ☐ 4 Years ☐ 3 Years ☐ 2 Years
4. Elimination Period ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days * Please refer to Partnership Program requirements above.	**4. Elimination Period** ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days * Please refer to Partnership Program requirements above.
5. Inflation Protection Riders (may select only one) ☐ 5% Compound Inflation Protection ☐ 3% Compound Inflation Protection ☐ 5% Simple Inflation Protection	**5. Inflation Protection Riders (may select only one)** ☐ 5% Compound Inflation Protection ☐ 3% Compound Inflation Protection ☐ 5% Simple Inflation Protection
6. Return of Premium Riders (may select only one) ☐ Full Return of Premium on Death (*available to age 65*) ☐ Return of Premium on Death **Beneficiary Name** _____ **Relationship** _____ (Designation of Beneficiary is applicable only in conjunction with one of the Return of Premium Riders)	**6. Return of Premium Riders (may select only one)** ☐ Full Return of Premium on Death (*available to age 65*) ☐ Return of Premium on Death **Beneficiary Name** _____ **Relationship** _____ (Designation of Beneficiary is applicable only in conjunction with one of the Return of Premium Riders)
7. Elimination Period Riders (may select only one) (not available with Facility Services Only Plan) ☐ HCBS Waiver of Elimination Period ☐ Enhanced Elimination Period	**7. Elimination Period Riders (may select only one) (not available with Facility Services Only Plan)** ☐ HCBS Waiver of Elimination Period ☐ Enhanced Elimination Period
8. Other Riders ☐ Shortened Benefit Period Nonforfeiture ☐ Restoration of Benefits *(not available w/ Lifetime Benefit Period)*	**8. Other Riders** ☐ Shortened Benefit Period Nonforfeiture ☐ Restoration of Benefits *(not available w/ Lifetime Benefit Period)*
9. Covered Partner Riders (if applying as Covered Partners both must select any of the following riders) ☐ Waiver of Premium for Covered Partner ☐ Paid-Up Survivor *(available only w/Lifetime Premium Payment Option)* ☐ Shared Care **(Covered Partner coverage must be identical)** *(not available w/Lifetime Benefit Period)*	**9. Covered Partner Riders (if applying as Covered Partners both must select any of the following riders)** ☐ Waiver of Premium for Covered Partner ☐ Paid-Up Survivor *(available only w/Lifetime Premium Payment Option)* ☐ Shared Care **(Covered Partner coverage must be identical)** *(not available w/Lifetime Benefit Period)*

SECTION 3: COVERAGE AND PREMIUM INFORMATION (continued)

* Please refer to Partnership Program requirements on page 2.	* Please refer to Partnership Program requirements on page 2.
10. REJECTION OF INFLATION PROTECTION RIDERS I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Inflation Protection Riders and I have chosen to reject these riders. Check Here ☐	**10. REJECTION OF INFLATION PROTECTION RIDERS** I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Inflation Protection Riders and I have chosen to reject these riders. Check Here ☐
11. REJECTION OF NONFORFEITURE RIDER I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to reject the rider. Check Here ☐	**11. REJECTION OF NONFORFEITURE RIDER** I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to reject the rider. Check Here ☐
12. Discounts (see Application Instructions) ☐ Covered Partner Discount (2 Proposed Applicants) ☐ Partner Discount (1 Proposed Applicant) ☐ Loyal Customer Discount Policy No. _____ ☐ Employer Group Discount Group Name and Number _____	**12. Discounts (see Application Instructions)** ☐ Covered Partner Discount (2 Proposed Applicants) ☐ Partner Discount (1 Proposed Applicant) ☐ Loyal Customer Discount Policy No. _____ ☐ Employer Group Discount Group Name and Number _____
13. Premium Billing (m*ay select only one*) ☐ List Bill ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ PAC	**13. Premium Billing (m*ay select only one*)** ☐ Direct Bill ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ PAC ☐ List Bill ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ PAC
14. Premium Payment Options (*may select only one)* ☐ Standard Lifetime ☐ Discounted Renewals *(only available with Lifetime Premium Payment)* *The following two options are not available under age 40* ☐ 10-Year ☐ Paid-Up at Age 65 *(available to age 55)*	**14. Premium Payment Options (*may select only one)*** ☐ Standard Lifetime ☐ Discounted Renewals *(only available with Lifetime Premium Payment)* *The following two options are not available under age 40* ☐ 10-Year ☐ Paid-Up at Age 65 *(available to age 55)*
Special Request:	Special Request:

SECTION 4: OTHER COVERAGE/REPLACEMENT INFORMATION

Proposed Applicant 1	**Proposed Applicant 2**
1. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including health care service contract or health maintenance organization contract)? ☐ Yes ☐ No	1. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including health care service contract or health maintenance organization contract)? ☐ Yes ☐ No
2. Did you have another long term care insurance policy or certificate in force during the past 12 months? ☐ Yes ☐ No If that policy lapsed, provide date of lapse _____	2. Did you have another long term care insurance policy or certificate in force during the past 12 months? ☐ Yes ☐ No If that policy lapsed, provide date of lapse _____
3. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy? ☐ Yes ☐ No	3. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy? ☐ Yes ☐ No
If you answered YES to any of the questions 1-3 above, provide full details below and complete the required replacement form(s):	If you answered YES to any of the questions 1-3 above, provide full details below and complete the required replacement form(s):
Question No. _____ Company/Carrier: _____ Type of Policy: _____ Issue Date: _____ Daily Benefit Amount: $_____ Paid to Date: _____	Question No. _____ Company/Carrier: _____ Type of Policy: _____ Issue Date: _____ Daily Benefit Amount: $_____ Paid to Date: _____
Question No. _____ Company/Carrier: _____ Type of Policy: _____ Issue Date: _____ Daily Benefit Amount: $_____ Paid to Date: _____	Question No. _____ Company/Carrier: _____ Type of Policy: _____ Issue Date: _____ Daily Benefit Amount: $_____ Paid to Date: _____

SECTION 5: PROTECTION AGAINST UNINTENTIONAL LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

Proposed Applicant 1 (choose one):	**Proposed Applicant 2 (choose one):**
☐ I elect not to designate any person to receive such notice ☐ I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium: Name: _____ Address: _____ Phone: (_____)_____ Relationship: _____	☐ I elect not to designate any person to receive such notice ☐ I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium: Name: _____ Address: _____ Phone: (_____)_____ Relationship: _____

SECTION 6: COVERED PARTNER OR PARTNER DISCOUNT ELIGIBILITY

To be eligible for the Partner Discount you must be

- married; or
- named in a valid certificate or license of civil union recognized by the state in which the Policy is issued; or
- living with someone for the past three consecutive years in a committed relationship as partners or as family members and sharing basic living expenses; and
  - are not married to each other or anyone else; and
  - not named in a certificate or license of civil union with each other or anyone else; and
  - if related, belong to the same family generation (e.g. siblings, cousins)

To be eligible for the Covered Partner Discount both applicants must meet the above criteria together.

I meet the criteria listed above. ☐ Yes ☐ No	I meet the criteria listed above. ☐ Yes ☐ No

SECTION 7: PROPOSED APPLICANT STATEMENT

NOTICE OF INSURANCE INFORMATION PRACTICES - To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. The information we obtain about you will be used by Massachusetts Mutual Life Insurance Company to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. The information obtained may not be released to any person or organization except to reinsuring companies, any third party administrators designated by Massachusetts Mutual Life Insurance Company or other persons or organizations performing services in connection with your application, claim or as may be otherwise lawfully required or as you may further authorize. We will furnish a more detailed summary of our information practices upon request.

AGREEMENT — The answers given on Part 1 of this application and my subsequent responses on Part 2 of the application are complete and true and were correctly recorded to the best of my knowledge and belief. I understand that the Company will rely on my written answers to the questions in Parts 1 and 2 of this application and that if my answers are not complete and true, my policy may not be valid. I also understand that the insurance producer cannot determine eligibility for or alter the terms of the proposed policy.

I understand that the policy will become effective and in force on the Policy Effective Date only if the following occur: (1) Parts 1 and 2 of this application are approved by the Company; (2) a policy is issued during the lifetime of the Proposed Applicant; (3) the first premium is paid in full; and (4) there has been no change in the insurability of the Proposed Applicant since the date of completion of Parts 1 and 2 of the application and the date the policy is delivered.

ACKNOWLEDGMENT — I acknowledge receipt of an Outline of Coverage, NAIC Shopper's Guide, Potential Rate Increase Disclosure Form, and the Company's notices about the Medical Information Bureau, Inc. (MIB), the Fair Credit Reporting Act, the Company's privacy practices, and the HIPAA Notice of Privacy Practices.

AUTHORIZATION FOR DISCLOSURE, RECEIPT AND USE OF PERSONAL HEALTH INFORMATION —

❑ Complete and submit F8186CO with this application.

NOTICE: 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.

This application (including Parts 1 and 2) will be part of the insurance policy for which I am applying. Further, if this application has been completed by two Proposed Applicants I understand that a copy of this application will be included in my Covered Partner's policy. "I", "you", and "your" mean the Proposed Applicant 1 and if applicable, Proposed Applicant 2 applying for coverage under this application.

CAUTION: If your answers on this application are incorrect or untrue, Massachusetts Mutual Life Insurance Company may have the right to deny benefits or rescind your policy.

Signed at _____ **On** _____
(City) (State) (Date)

Signature of Proposed Applicant 1: _____

Signature of Proposed Applicant 2: _____

SECTION 8: INSURANCE PRODUCER'S STATEMENT

8A: Rate Information

What Rate Class was proposed?	Did you consult the Field Underwriting Guide to determine rate class?
Proposed Applicant 1: ☐ Ultra Preferred ☐ Select Preferred ☐ Preferred	☐ Yes ☐ No
Proposed Applicant 2: ☐ Ultra Preferred ☐ Select Preferred ☐ Preferred	

8B: Other Coverage and Replacement Information

Is this part of a multi-Life case (i.e. family members, business partners, etc.)?	Is there a Disability or Life Application being submitted concurrently with this Application?
Proposed Applicant 1: ☐ Yes ☐ No	Proposed Applicant 1: ☐ Yes ☐ No
Proposed Applicant 2: ☐ Yes ☐ No	Proposed Applicant 2: ☐ Yes ☐ No

Proposed Applicant 1	**Proposed Applicant 2**
To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any company? ☐ Yes ☐ No	To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any company? ☐ Yes ☐ No
List any other health insurance policies that you have sold to the Proposed Applicant(s): _____	List any other health insurance policies that you have sold to the Proposed Applicant(s): _____
Which of the policies listed above are still in force, if any? _____	Which of the policies listed above are still in force, if any? _____
Which of the policies listed above sold in the past 5 years are no longer in force, if any? _____	Which of the policies listed above sold in the past 5 years are no longer in force, if any? _____

8C: Forms Delivery and Signatures

Did you provide Proposed Applicant(s) with all required notices? ☐ Yes ☐ No	Did you ask the Proposed Applicant(s) all the questions face to face and witness their signature(s)? ☐ Yes ☐ No
(if "No", provide details)	(if "No", provide details)

I certify that the answers to the questions provided by the Proposed Applicant(s) were fully and accurately recorded in the application, and that the questions in the Insurance Producer's Statement have been answered accurately. I have reviewed the current health insurance coverage of the Proposed Applicant(s) and find that the coverage of the type and amount applied for is appropriate for the needs of the Proposed Applicant(s). Further, if this is a replacement, I have reviewed the current health insurance coverage of the Proposed Applicant(s) and find that this replacement is appropriate for the needs of the Proposed Applicant(s).

Licensed Insurance Producer's Name (please print) _____ **Ident. Code** _____

Licensed Insurance Producer's Signature _____ **Date** _____

Insurance Producer's Phone _____

Insurance Producer's Fax _____ **Agency Number** _____

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

Long Term Care Insurance
Personal Worksheet

People buy long term care insurance for many reasons. Some don't want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid, but long term care insurance may be expensive and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number: _____

The premium for the coverage you are considering will be $ _____ per _____ .

Type of Policy: Guaranteed Renewable

The Company's Right To Increase Premiums

The Company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History

The company has sold long term care insurance since 2000 and has sold this policy since 2008. The company has never raised its rates for any long term care policy it has sold in this state or any other state.

Questions Related To Your Income

How will you pay each year's premium?

❍ From my income ❍ From my Savings/Investments ❍ My family will pay

❍ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What Is Your Annual Income? (check one)

❍ Under $10,000 ❍ $10-20,000 ❍ $20-30,000 ❍ $30-50,000 ❍ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

❍ No change ❍ Increase ❍ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Turn the Page

Will You Buy Inflation Protection? (check one) ❍ Yes ❍ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

❍ From my income ❍ From my Savings/Investments ❍ My family will pay

The national average annual cost of care in 2008[1] was: $68,000 in a nursing home; $36,000 in an assisted living facility and $18,000 for home health care, but these figures vary across the country. In ten years the national average annual cost would be about $110,765 in a nursing home; $58,640 in an assisted living facility and $29,320 for home health care, if costs increase 5% annually.

What Elimination Period Are You Considering? Number of Days _____
Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

❍ From my income ❍ From my Savings/Investments ❍ My family will pay

Questions Related To Your Savings and Investments

Not counting your home, about how much are all of your assets (savings and investments) worth? (check one)

❍ Under $20,000 ❍ $20,000-30,000 ❍ $30,000-50,000 ❍ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

❍ Stay about the same ❍ Increase ❍ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long term care.

Comparison To Current Coverage

If you have existing long term care coverage and you intend to add to or replace your current coverage, please indicate your reason for doing so (check one):

❍ Additional or different benefits (please specify): _____

❍ No change in benefits, but lower premiums

❍ Fewer benefits and lower premiums

❍ Other (please specify): _____

Premium for your current long term care coverage: $ _____ per _____ .

[1] 2008 U.S. Department of Health and Human Services (www.longtermcare.gov/LTC/Main_Site/index.aspx)

Continued on Next Page

Disclosure Statement

(Check One)

❍ The answers to the questions above describe my financial situation.

Or

❍ I choose not to complete this information. However, I still want the Company to consider my application.

Authorization to Process Application

My insurance producer has explained to me that my personal financial circumstances are an important consideration in determining whether or not long term care insurance is an appropriate purchase for me.

My insurance producer has also given me a copy of "*Things You Should Know Before You Buy Long Term Care Insurance*" and has explained the importance of completing the Long Term Care Insurance Personal Worksheet.

I hereby confirm that I have chosen not to complete the Long Term Care Insurance Personal Worksheet. Nevertheless, I request that you continue to process my application for long term care insurance.

❍ I acknowledge that the insurer and/or its insurance producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** *(This box must be checked in order to consider your application for Long Term Care.)*

Signed: _____ _____

(Proposed Applicant 1) (Date)

_____ _____

(Proposed Applicant 2) (Date)

❍ I explained to the proposed applicant(s) the importance of completing this information.

Signed: _____ _____

(Insurance Producer) (Date)

_____

(Insurance Producer's Printed Name)

IN ORDER FOR US TO PROCESS YOUR APPLICATION, PLEASE RETURN THIS SIGNED STATEMENT TO MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY, ALONG WITH YOUR APPLICATION.

My insurance producer has advised me that this policy does not appear to be suitable for me. However, I still want the Company to consider my application.

Signed: _____ _____

(Proposed Applicant 1) (Date)

_____ _____

(Proposed Applicant 2) (Date)

The Company may contact you to verify your answers.

This confidential information will be used only to determine your suitability for long term care insurance and may not be used for any other purpose or disseminated outside of the Company or agency.

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Authorization for Release of Personal Health-Related Information
This authorization complies with the HIPAA Privacy Rule

_____ ____/____/____
Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other personal health information concerning me. I further authorize any insurance company, my insurance producer, the MIB, Inc., pharmacy data search companies, consumer reporting agencies, the Department of Motor Vehicles or other state or federal government agency ("Other Persons") that has any record or knowledge of me or my health to give the Companies all such information.

This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases unless otherwise restricted under state law. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but 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 counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes (meaning the following information is included in this authorization) medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers and Other Persons to release and disclose my entire medical record without restriction.

This information may be disclosed to the Massachusetts Mutual Life Insurance Company and its affiliated insurance companies, its producers, employees, and representatives (collectively referred to as "The Companies") and its reinsurers.

The Companies and its reinsurers may disclose information obtained by this authorization to the MIB, Inc., reinsurers my insurance producer, and other persons and entities performing business or legal services in connection with my application.

I understand that a copy of my application will be attached to my policy at time of delivery and further may also be attached to any policy of a co-applicant who is issued coverage as a result of the same application.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance, enrollment and premium determinations; 2) obtain reinsurance; and 3) conduct other legally permissible activities that relate to any coverage I have applied for with The Companies.

This authorization shall remain in force for 24 months following the date of my signature below, and a photocopy or facsimile of this authorization is as valid as the original.

I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to **Massachusetts Mutual Life Insurance Company and its affiliated insurance companies at 1295 State Street, Springfield, MA 01111-0001 Attention: Authorization Administrator.** I understand that a revocation is not effective to the extent that any of My Providers or Other Persons have relied on this Authorization or to the extent that The Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that some information obtained pursuant to this authorization may be disclosed to persons or organizations that are not subject to the federal health information privacy laws and no longer protected under such laws. I further understand that such information may be re-disclosed only in accordance with applicable laws or regulations.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Companies may not be able to process my application. I acknowledge that I have received a copy of this authorization.

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Signature of Proposed Insured/Patient or Personal Representative Date

_____
Print name of signature above

_____
Description of Personal Representative's Authority or Relationship to Patient

This copy to Home Office with application

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Print name of signature above

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Description of Personal Representative's Authority or Relationship to Patient

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Print name of signature above

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Description of Personal Representative's Authority or Relationship to Patient

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long term care expenses.

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

You have received this Notice because you have applied for or have long term care insurance coverage ("LTC Coverage") with Massachusetts Mutual Life Insurance Company ("MassMutual ").

We collect, use and disclose information about you to evaluate and process any requests for coverage and claims for benefits you may make regarding your LTC Coverage. This Notice describes how we safeguard the protected health information we have about you which relates to your LTC Coverage ("Protected Health Information"), and how we may use and disclose this information. Protected Health Information includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This Notice also describes your rights with respect to the Protected Health Information and how you can exercise those rights.

We are required by law to maintain the privacy of your Protected Health Information; to provide you this Notice of our legal duties and privacy practices with respect to your Protected Health Information; and to follow the terms of this Notice.

We reserve the right to change the terms of this Notice. Any such changes will apply to all Protected Health Information that we already have about you as well as any Protected Health Information that we may receive in the future. If we make a material change to the terms of the Notice, we will promptly send the revised Notice to you should you still maintain coverage with us when the revised Notice becomes effective.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following describes when we may use and disclose your Protected Health Information:

Use and Disclosure with Your Authorization: Except as described below, we will not use or disclose your Protected Health Information for any reason unless we have a signed authorization from you or your legal representative. Please contact us to obtain a form. You or your legal representative have the right to revoke an authorization in writing, except to the extent that we have taken action relying on the authorization, or if the authorization was obtained as a condition of obtaining your LTC coverage, or to the extent that we have a legal right to contest a claim under the policy or to contest the policy itself.

Use and Disclosure for Treatment. We may use and disclose your Protected Health Information as necessary for your treatment. For example, we may disclose at claim time your current health status to Licensed Health Care Practitioners to allow them to manage, coordinate and administer your treatment.

Use and Disclosure for Payment: We may use and disclose your Protected Health Information as necessary for payment purposes. For example, when you present a claim for LTC benefits, we may

obtain medical records from the doctor or health facility involved in your care to determine if you are eligible for benefits under the insurance policy and to pay benefits under your policy.

Use and Disclosure for Health Care Operations: We may use and disclose your Protected Health Information as necessary for our health care operations which may include underwriting, premium rating, and other activities related to the issuance, renewal or replacement of LTC Coverage, or for reinsurance purposes. For example, when you apply for insurance we may collect medical information from your doctor (health care provider) or a medical facility that provided you health care services to determine if you qualify for insurance. We may also use and disclose Protected Health Information to conduct or arrange for medical review, legal services, business planning and development regarding the management and operation of our LTC Coverage processes, or auditing, including fraud and abuse detection and compliance programs. Protected Health Information may also be disclosed for customer service, servicing our current and future customer relationship as permitted by law, resolution of internal grievances and as part of a potential sale, transfer, merger, or consolidation in order to make an informed business decision regarding any such prospective transaction.

Uses and Disclosures to Family, Friends or Others Involved in Your Care: With your written approval, we may disclose your Protected Health Information to designated family, friends, personal representatives, or other individuals that you may identify as involved in your care or involved in the payment for your care. Should you become incapacitated or be in the face of an emergency medical situation and not able to provide us with your written approval, we may disclose Protected Health Information about you that is directly relevant to such person's involvement in your care or payment for such care.

Use and Disclosure with Business Associates: We may also disclose Protected Health Information to business associates, but only if the receipt of Protected Health Information is necessary to provide a service to us and the business associate agrees to protect the Protected Health Information according to HIPAA rules. Some examples of business associates are licensed insurance agents, third party administration services companies, auditors, attorneys and claims processing companies.

Other Uses and Disclosures: We are permitted or required by law to make the following uses or disclosures of your Protected Health Information without your authorization:

• Releasing Protected Health Information to state or local health authorities, as required by law, about particular communicable diseases, injury, birth, death, and for other required public health investigations;

• Releasing Protected Health Information to a governmental agency or regulator with health care oversight responsibilities;

• Releasing Protected Health Information to a coroner, medical examiner or funeral director to assist in identifying a deceased individual or to determine the cause of death;

• Releasing Protected Health Information to public health or other appropriate authorities, as required by law, when there is reason to suspect abuse, neglect, or domestic violence;

• Releasing Protected Health Information to the Food and Drug Administration (FDA) for purposes related to quality, safety or effectiveness of FDA-regulated products or activities;

• Releasing Protected Health Information if required by law to do so by a court or administrative ordered subpoena or discovery request, or for law enforcement purposes as permitted by law once we have met all administrative requirements of the HIPAA Privacy Rule. We may disclose Protected Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination;

• Releasing Protected Health Information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;

• Releasing Protected Health Information if you are a member of the military as required by armed forces services;

• Releasing Protected Health Information to federal officials for intelligence, counterintelligence, and other national security activities authorized by law;

• Releasing Protected Health Information to worker's compensation agencies if necessary for your worker's compensation benefit determination;

• Releasing Protected Health Information to avert a serious threat to someone's health or safety, including the disclosure of Protected Health Information to government or disaster relief or assistance agencies to allow such entities to carry out their responsibilities to specific disaster situations.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Any request to exercise your rights as described below should be made in writing and sent to **Massachusetts Mutual Life Insurance Company, Long Term Care Administrative Office, ATTN: HIPAA PRIVACY ADMINISTRATION, P.O. Box 4243, Woodland Hills, CA 91365-4243.** Also, should you wish to terminate a request that has been accommodated, such termination request must also be in writing and sent to the same address listed above. Your request should include the following information: your full name, address, and policy number. Generally, we will respond to these requests within 30 days of receipt.

Right to Request Restrictions: You have the right to request restrictions on certain of our uses or disclosures of your Protected Health Information for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member, friend or personal representative. You should submit your submission request in writing. While we will consider your request, we are not required to agree to your restriction. If we do agree to the restriction, we will not use or disclose your Protected Health Information as requested, but reserve the right to terminate the agreed to restriction if such termination is deemed appropriate. In your request to restrict use and disclosure, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on Protected Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

Right to Request Confidential Communications: You have the right to request that we communicate with you about Protected Health Information in a certain way or at a certain location if you inform us that disclosure of such information will otherwise endanger you. Such a request must be in writing and sent to the address listed above. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Inspect and Copy Your Protected Health Information: In most instances, you have the right to inspect and obtain a copy of the Protected Health Information that we maintain about you. Your request must be in writing and sent to the address listed above. We will deny inspection and copying of certain Protected Health Information, for example psychotherapy notes and Protected Health Information collected by us in connection with, or in reasonable anticipation of any administrative claim or legal proceeding. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. In those circumstances that we may deny your request to inspect and obtain a copy of your Protected Health Information, you have the right to request a review of our denial.

Right to Amend Your Protected Health Information: You have the right to request that we amend your Protected Health Information in our records if you believe that it is inaccurate or incomplete. Your request must be in writing and sent to the address listed above. If an amendment or correction request is accepted, we will amend or correct all appropriate records as well as notify others to whom we have disclosed the erroneous Protected Health Information. We may deny your request if you ask

us to amend Protected Health Information that is accurate and complete; was not created by us, unless the creator of Protected Health Information is no longer available to make the amendment; is not part of the Protected Health Information kept by or for us; or is not part of the Protected Health Information which you would be permitted to inspect and copy. If we deny your request, we will provide you with an explanation for our denial and any further rights you may have regarding your request to amend.

Right to Receive an Accounting of Disclosures of Your Protected Health Information: You have the right to request an accounting or list of disclosures we have made of your Protected Health Information. This list will not include disclosures made for payment or health care operations, made for purposes of national security, made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to the address listed above. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. We reserve the right to charge you for responding to any additional requests within the same 12 month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, you must submit a written complaint to the address listed above. You can be assured that you will not be retaliated against by MassMutual for filing a complaint.

For Further Information: For further information regarding this Notice or MassMutual's privacy practices, please contact **Massachusetts Mutual Life Insurance Company, Long Term Care Administrative Office, ATTN: HIPAA PRIVACY ADMINISTRATION, P.O. Box 4243, Woodland Hills, CA 91365-4243.**

Effective Date: This Notice is effective August 16, 2010.

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 money. Among our policyholders, the additional cost varies depending upon the type of policy and its original issue date. A generic description of the payment options and range of costs, expressed 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 charge.

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 charge 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 charge 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 charge in the range of $20 to $103 on an annual premium of $1,000.

There may be other premium payment options available 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 charge 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 policy. In order to make a change, you must either:

- Inform your MassMutual agent that you wish to change the premium payment frequency 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 policy number in your correspondence; or
- Contact a MassMutual Customer Service Representative at 1-800-272-2216 and inform the representative that you wish to change the premium payment frequency 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.

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or insurance producer gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
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Long Term Care Insurance Potential Rate Increase Disclosure Form

1. **Premium Rate:** The premium rate that is applicable to you and the coverage you have applied for is shown on the application.
2. **The premium for the Policy and any riders that are issued to you will be shown on the Benefit Schedule of your Policy. This rate will be in effect unless and until the Company requests a premium rate increase and it is approved by the state in which your Policy was issued.**
3. **Rate Schedule Adjustments:**

   Premium rate or rate schedule adjustments will be effective on the next Policy Anniversary Date following the date the state approves a rate increase.
4. **Potential Rate Revisions:**

   This Policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a Policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your Policy in force as is.
   - Reduce your Policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture option.* (This option may be available to you if you do not purchase a separate nonforfeiture option.)

***<u>Contingent Nonforfeiture</u>**

If the premium rate for your Policy goes up in the future and you didn't buy a nonforfeiture option you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long term care coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your Policy was first issued. If you have already received benefits under the Policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other Policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your Policy, with this reduced maximum benefit amount will be considered "paid-up" with no further premiums due.

Turn the Page

Example:

- You bought the Policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the Policy (not pay any more premiums).
- Your "paid-up" Policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your Policy.)

Contingent Nonforfeiture **Cumulative Premium Increase Over Initial Premium That Qualifies for Contingent Nonforfeiture** (Percentage Increase is cumulative from the date of original issue. It does NOT represent a one-time increase)			
Issue Age	**Percent Increase Over Initial Premium**	**Issue Age**	**Percent Increase Over Initial Premium**
40-44	150%	71	38%
45-49	130%	72	36%
50-54	110%	73	34%
55-59	90%	74	32%
60	70%	75	30%
61	66%	76	28%
62	62%	77	26%
63	58%	78	24%
64	54%	79	22%
65	50%	80	20%
66	48%	81	19%
67	46%	82	18%
68	44%	83	17%
69	42%	84	16%
70	40%	85	15%

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your Policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase	
Issue Age	**Percent Increase Over Initial Premium**
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced "paid-up" Policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the Policy becomes "paid-up" by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the Policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" Policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" 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.