MassMutual FINANCIAL GROUP®

Application for Individual Life or Individual Disability Income Insurance (Part 2)

To the Company as defined below:

☐ **Massachusetts Mutual Life Insurance Company,** 1295 State Street, Springfield, Massachusetts 01111-0001
☐ **C.M. Life Insurance Company,** 100 Bright Meadow Boulevard, Enfield, Connecticut 06082
☐ **MML Bay State Life Insurance Company,** 100 Bright Meadow Boulevard, Enfield, Connecticut 06082

Use this Application to provide additional information on the Proposed Insured. Complete all sections for all cases.

A Personal Information

1. Proposed Insured full legal name *(First, MI, Last, Suffix):* _____
2. Date of birth *(mm/dd/yyyy):* _____
3. Social Security Number or Taxpayer Identification Number: _____
4. Current height *(Feet and Inches):* _____ Current weight *(Pounds):* _____
5. Has your weight changed by more than 10 pounds in the last year? ☐ Yes ☐ No
   If Yes, how much? _____ Due to? ☐ Diet ☐ Other
6. Current primary physician name *(First, MI, Last, Suffix):* _____
   a. Physician business address *(Street, Suite #, City & State or Country, ZIP/Postal Code):*
   _____
   _____
   b. Physician Phone Number: (_____) _____ – _____
   c. Date last seen by physician and reason: _____
   _____
7. Family History.
   a. Complete all sections of the grid below, except "Diagnosis", for all immediate family members (parents and siblings):

Relative	Diagnosis – Include Age of Onset	Age if Living	Age at Death	Cause of Death
Father				
Mother				
Brother(s)/Sister(s)				

Have any of the family members listed above been diagnosed or treated by a member of the medical profession for:

b. Heart Disease, vascular (blood vessel) disease or cancer? ☐ Yes ☐ No
c. A familial condition of the brain, muscles, nervous system or kidneys? ☐ Yes ☐ No

If 7b or 7c is Yes, complete "Diagnosis" in the table above. If additional space is required, use section C-Additional Information.

B Personal History Information

If Proposed Insured answers Yes to any question, provide additional information in Supplement A.

1. Has the Proposed Insured used tobacco or other nicotine containing products *(e.g. cigarettes, pipes, cigars, snuff, chewing tobacco or nicotine delivery device such as gum or the patch):*
   a. Within the last 12 months? ☐ Yes ☐ No
   b. Within the last 24 months? ☐ Yes ☐ No

B Personal History Information *continued*

2. Is the Proposed Insured currently:
   a. Under treatment by a member of the medical profession or taking any prescription medications (other than contraceptives)? ☐ Yes ☐ No
   b. Taking any herbal or non-prescription medication at least weekly? ☐ Yes ☐ No
   c. Pregnant? ☐ Yes ☐ No
   If Yes, expected delivery date: _____

3. In the past 10 years, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder noted below:
   a. Chest pain, heart attack, high blood pressure, heart murmur, palpitations or any other disorder of the heart, arteries or veins? ☐ Yes ☐ No
   b. A tumor or cancer including skin cancer, melanoma or colon polyps? ☐ Yes ☐ No
   c. A disorder of the blood, spleen or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia or lymphoma? ☐ Yes ☐ No
   d. A disorder of the brain, spinal cord or nervous system including seizures, tremors, paralysis, dizziness, fainting, headaches, stroke or TIA (transient ischemic attack)? ☐ Yes ☐ No
   e. Depression, anxiety, nervousness, stress, psychosis, suicide thoughts or attempts, anorexia or bulimia, post traumatic stress disorder, obsessive compulsive disorder, bipolar disorder, attention deficit hyperactivity disorder (ADHD) or other emotional disorder? ☐ Yes ☐ No
   f. A disorder of the eyes, ears, nose, throat or sinuses including any partial or complete loss of hearing, vision or speech? ☐ Yes ☐ No
   g. Asthma, allergies, shortness of breath, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), pneumonia, sleep apnea, tuberculosis or any other disorder of the respiratory system? ☐ Yes ☐ No
   h. A disorder of the digestive system, liver, pancreas or gall bladder including hepatitis, jaundice, ulcers, intestinal bleeding, colitis, Crohn's disease (ileitis), recurrent indigestion, diarrhea or diverticulitis? ☐ Yes ☐ No
   i. A disorder or impairment of the muscles, bones, joints, nerves, spine, neck or back including arthritis, gout, sciatica or amputations? ☐ Yes ☐ No
   j. Epstein-Barr virus, Lyme disease, chronic fatigue syndrome, fibromyalgia, lupus or other rheumatologic disorder? ☐ Yes ☐ No
   k. Diabetes or a disorder of the thyroid, pituitary or adrenal glands? ☐ Yes ☐ No
   l. A disorder of the kidneys, bladder, prostate or urinary tract or findings of sugar, protein or blood in the urine? ☐ Yes ☐ No
   m. A disorder of the skin including eczema or psoriasis? ☐ Yes ☐ No
   n. A diagnosis of Human Immunodeficiency Virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
   o. A disorder of the uterus, cervix, ovaries or breasts? ☐ Yes ☐ No
   p. Multiple miscarriages, complicated pregnancy or infertility evaluation? ☐ Yes ☐ No

4. In the last 10 years, has the Proposed Insured:
   a. Used cocaine, barbiturates, amphetamines, heroin, narcotics, stimulants, hallucinogens or other controlled substances or habit forming drugs not prescribed by a physician? ☐ Yes ☐ No
   b. Received medical treatment, attended a program or been counseled for alcohol or drug abuse or been advised by a member of the medical profession to reduce the use of alcohol? ☐ Yes ☐ No

5. In the last 5 years, has the Proposed Insured:
   a. Had an application for life, disability or health insurance declined, postponed, rated or restricted? ☐ Yes ☐ No
   b. Had a sickness or injury for which a disability claim was made or payments, benefits or pension benefits were received? ☐ Yes ☐ No

6. In the last 3 years, unless previously stated on the application, has the Proposed Insured:
   a. Had a physical exam, check-up or evaluation by a member of the medical profession? ☐ Yes ☐ No
   b. Had an injury treated by a health professional or medical facility? ☐ Yes ☐ No
   c. Had an electrocardiogram, x-ray, blood test or other diagnostic test, excluding an HIV test? ☐ Yes ☐ No
   d. Had surgery or been a patient in a hospital, clinic or other medical or mental health facility? ☐ Yes ☐ No
   e. Been advised by a member of the medical profession to have surgery, medical treatment or diagnostic testing, excluding HIV testing that has not been completed? ☐ Yes ☐ No

C Additional Information

Details. *Provide additional details for questions answered Yes. Use Supplement 'A' for additional space.*

Question	Details and Medications	Name of Physician	Address of Physician

D Agreements & Signatures

I, the undersigned, have read the Application and all statements and answers as they pertain to me, and affirm that these statements and answers are true, complete and correctly recorded to the best of my knowledge and belief. The statements and answers in the application are the basis for any Policy issued by MassMutual and no information about me will be considered to have been given to MassMutual unless it is stated in the application. I hereby adopt all statements made in the application and agree to be bound by them.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

Signed at *(City & State)*: _____ Date: _____

▶ Signature of Proposed Insured: _____

Printed Name: _____ Date: _____

▶ Signature of Witness: _____

Printed Name: _____ Date: _____

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Supplement "A" to Application Part 2

Use this supplement to provide additional information for questions answered Yes.

A Personal Information

1. Proposed Insured full legal name *(First, MI, Last, Suffix):* _____
2. Date of birth *(mm/dd/yyyy):* _____
3. Social Security Number or Taxpayer Identification Number: _____

B Additional Information

Question	Details and Medications	Name of Physician	Address of Physician

Signature of Proposed Insured: _____

Printed Name: _____ Date: _____

Signature of Witness: _____

Printed Name: _____ Date: _____

MassMutual Financial Group is a marketing name for Massachusetts Mutual Life Insurance Company (MassMutual) and its affiliated companies and sales representatives.