MassMutual FINANCIAL GROUP

APPLICATION INSTRUCTIONS

The Employer Name and Employer Group Policy Number have been pre-filled for your convenience. Please review the application carefully and complete the required questions.

- This application must be completed in black ink.
- Do not answer questions with dashes, ditto marks or N/A.
- Any corrections or erasures must be initialed by the applicant.
- Ensure that whenever required in the application, the Social Security Number or the Tax ID number is completed accurately.
- Fill in the Employee information section completely.
- Use the Rate Card included with your Application Package to select the options right for you and complete the following sections.

  Note: Premium rate is calculated using your age as of the Effective Date of the Certificate.

  Example: **Applicant DOB is 7/19/1977 and is 40 years old**
  Application is signed 8/1/2017
  Effective Date of Coverage is 9/1/2017
  Rates based on a 40 year old as of 9/1/2017

  Applicant DOB is 8/25/1980 and is 36 years old
  Application is signed 8/1/2017
  Effective Date of Coverage is 9/1/2017
  Rates based on a 37 year old as of 9/1/2017
- For **Group Whole Life**:
  - Enter Face Amount
  - Select Optional Riders
    - Enter the Total Monthly Premium
  - Select an automatic Premium Loan option.
  - Select a Dividend option
- Enter Beneficiary information
- Complete all Underwriting questions
- Select Dependent Coverage options:
  - Enter Dependent Information
  - Enter the Total Monthly Premium
- Complete all Dependent Underwriting questions
  - For question #2, answer for spouse and all children
  - For question #3, answer for spouse only
- Review the Taxpayer Identification information and if any of the statements are ***incorrect***, please check the box in front of the statement that is **NOT** true.
- Review, sign and date Applicant Statement & Acknowledgement
- Application must be received no later than **Five Days After the Enrollment End Date.**

Regular Mail:

Massachusetts Mutual Life Insurance Company
Attn: CIS Imaging Dept - Mailroom
P.O. Box 19015
Greenville, SC 29602-9015

Overnight Mail:

Massachusetts Mutual Life Insurance Company
Attn: CIS Imaging Dept - Mailroom
2000 Wade Hampton Blvd.
Greenville, SC 29615

Or

Fax to: (877) 888-2677

For additional application guidance or questions, call our Enrollment Support Center at (844) 667-5223 or your Producer.

MassMutual FINANCIAL GROUP

Application for MassMutual@Work
Group Whole Life Insurance

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

Group Name: ____Fairfax County Police Association_____ Group Number: __71127_____

Employee Information

Full Legal Name *(First, MI, Last, Suffix)*			Date of Birth *(mm/dd/yyyy)*
Social Security Number/Tax ID	Gender ☐ Male ☐ Female	Annual Salary/Compensation	Current Occupation
Residential Address **Do not use PO Box* Street			
City		State or Country	ZIP/Postal Code
Mailing Address **Only if different than residential address* Street			
City		State or Country	ZIP/Postal Code
Phone Number: ☐ Mobile ☐ Home ☐ Work	Email Address		Preferred Contact Method: ☐ Mailing address ☐ Phone ☐ Email

Group Whole Life

Employee Benefit Selection(s)	Included Riders		
Face Amount $_____		Accidental Death Benefit: 2 times Face Amount	
☐ Spouse/Domestic Partner Term Life Insurance Rider*	☐ $10,000 ☐ $20,000	Age of Spouse/Domestic Partner: _____	
☐ Child Term Life Insurance Rider*	☐ $10,000 ☐ $20,000	Age of Youngest Child _____	
		Total Monthly Premium	$_____

Product Features: (Elections will apply to all Group Whole Life Certificates)

1. Automatic Premium Loan:
☐ Yes ☐ No

2. Dividend Option (Select one):
☐ Paid-Up Additions (default) ☐ Reduce Premiums (Not available with payroll deduction)
☐ Dividend Accumulations ☐ Cash

Beneficiary Information

☐ Single Beneficiary (100% distribution) *If selected, complete section below* ☐ Other *If selected, use the Beneficiary Form*
If no beneficiary is designated, then the default beneficiary will be the estate of the Insured.

Full Legal Name *(First, MI, Last, Suffix)*	Relationship to Insured
Social Security Number/Tax ID	Date of Birth *(mm/dd/yyyy)*
Address (Street, City, State, ZIP)	Phone number

Underwriting Information

Complete the following required questions.

1. Within the last 12 months, have you used tobacco or other nicotine containing products *(e.g. cigarettes, pipe, snuff, chewing tobacco or nicotine delivery device such as gum, e-cigarette, or the patch)*, or smoked more than 24 cigars? ☐ Yes ☐ No
2. Employee Are you actively at work at your usual and customary location, maintaining your normal work schedule, performing all the duties of your occupation without limitation due to injury or sickness? ☐ Yes ☐ No
   Member: If employed, other than self-employed, are you actively at work at your usual and customary location, maintaining your normal work schedule, performing all the duties of your occupation without limitation due to injury or sickness? If self-employed or not employed, are you currently applying for or collecting any disability benefits (including but not limited to Social Security Disability or reimbursements from Medicaid due to disability)?
3. During the last 2 years, have you sought treatment or been treated for, been prescribed medication for, or been diagnosed by a member of the medical profession as having, any of the following: ☐ Yes ☐ No

a. Cancer (excluding non-melanoma skin cancer)?
b. Alcohol or drug abuse?
c. Diabetes for which the recommended treatment is insulin?
d. Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy?
e. Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)?
f. Stroke or transient ischemic attack (TIA)?
g. Cirrhosis of the liver or hepatitis (excluding Hepatitis A)?
h. Parkinson's disease or paralysis?
i. Chronic kidney disease or kidney failure (excluding kidney stones)?
j. AIDS (Acquired Immune Deficiency Syndrome) or tested positive for HIV (Human Immunodeficiency Virus) or its antibodies?

Applicant Statements Acknowledgement and Signature

I acknowledge receiving the disclosure statement regarding the Accelerated Death Benefit For Terminal Illness feature, if required by the state I reside in.

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated Virginia law

I understand that I will be the owner of any Certificate issued as a result of this application. I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements I make which materially affect the acceptance of the risk assumed may result in loss of coverage under the Certificate to which the application is attached, subject to the incontestability provision. I understand that completion of this application in no way implies that I will be accepted for insurance coverage.

Taxpayer Identification – If any of the following statements are incorrect, please check the box in front of the statement that is NOT true.

By my signature, I, the Employee, certify under penalties of perjury that ☐ (1) the number shown in the Employee section is my correct Taxpayer Identification Number; ☐ (2) I am not subject to backup withholding; ☐ (3) I am a US person (including US resident alien); and (4) the FATCA code entered in this form (if any) indicating that I am exempt from FATCA (Foreign Account Tax Compliance Act) reporting is correct.
(Please note, while we are required by the IRS to include item number 4, FATCA does not apply to a US account owned by a US person, so we have not included the ability to enter an exemption code. If you have indicated that you are not a US person, any applicable FATCA information will be captured on the Form W-8BEN.)

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Employee Signature _____ Date _____

Producer Name _____ Agency Number _____

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

MassMutual FINANCIAL GROUP

Beneficiary Designation Form

Indicate usage below:

☐ *At time of application, use this form to designate multiple Beneficiaries.*

☐ *After issue, use this form to change the Beneficiary on existing MassMutual certificates.*

A Personal Information

1. Insured full legal name *(First, MI, Last, Suffix):* _____
2. Insured date of birth *(mm/dd/yyyy):* _____
3. Certificate Number *(After issue):* _____
4. Certificateowner full legal name *(First, MI, Last, Suffix):* _____
5. Certificateowner phone number: (_____) _____ – _____ Extension: _____ ☐ Home ☐ Work ☐ Mobile
6. Certificateowner email: _____ ☐ After issue, check to have confirmation sent by email.

B Beneficiary Information

1a. Class *(Select one):* ☐ Primary ☐ Secondary

Full legal name: _____

Mailing address: _____

Phone number: (_____) _____ - _____ Social Security Number/Tax ID: _____

Date of birth/Trust *(mm/dd/yyyy):* _____ Distribution *(If not equal shares):* %/$ _____

Relationship to Insured: _____

1b. Class *(Select one):* ☐ Primary ☐ Secondary

Full legal name: _____

Mailing address: _____

Phone number: (_____) _____ - _____ Social Security Number/Tax ID: _____

Date of birth/Trust *(mm/dd/yyyy):* _____ Distribution *(If not equal shares):* %/$ _____

Relationship to Insured: _____

1c. Class *(Select one):* ☐ Primary ☐ Secondary

Full legal name: _____

Mailing address: _____

Phone number: (_____) _____ - _____ Social Security Number/Tax ID: _____

Date of birth/Trust *(mm/dd/yyyy):* _____ Distribution *(If not equal shares):* %/$ _____

Relationship to Insured: _____

1d. Class *(Select one):* ☐ Primary ☐ Secondary

Full legal name: _____

Mailing address: _____

Phone number: (_____) _____ - _____ Social Security Number/Tax ID: _____

Date of birth/Trust *(mm/dd/yyyy):* _____ Distribution *(If not equal shares):* %/$ _____

Relationship to Insured: _____

B Beneficiary Information *continued*

To name additional beneficiaries, copy this page.

1e. Class *(Select one):* ☐ Primary ☐ Secondary

Full legal name: _____

Mailing address: _____

Phone number: (_____) _____ - _____ Social Security Number/Tax ID: _____

Date of birth/Trust *(mm/dd/yyyy):* _____ Distribution *(If not equal shares):* %/$ _____

Relationship to Insured: _____

C Disclosures

Beneficiary. Unless otherwise requested, proceeds shall be paid equally and in one sum as follows:

- If there is no living or existing beneficiary, the proceeds will be paid to the Certificateowner or the Certificateowner's estate.
- If Distribution Amounts/Percentages are designated, and a beneficiary predeceases the Insured, no longer exists or is no longer entitled to payment, that amount/percentage will be distributed to the surviving beneficiaries in that class as per the ratio designated.
- If dollar amounts are designated, and the proceeds at the death of the Insured are greater or less than the total amount designated, then the proceeds payable to each beneficiary will be adjusted so that the relative ratio between and among the beneficiaries remains the same.
- If a Trust under the Insured's Will is designated, then proceeds will be paid only if the Will is probated and if there is a trust in effect.
- If a revocable trust is the Certificateowner, and the trust is not in effect at the death of the Insured, and there is no living or existing beneficiary, the proceeds shall be paid to the designated grantor(s) equally, otherwise to the estate of whichever said grantors is the last to die.

General Provisions:

- MassMutual is only responsible to perform according to the terms of the policy, and is not responsible for carrying out the terms of any trust or any trust agreement outside of this policy.
- If no custodian is designated, any money payable to a minor will be paid to the court appointed guardian of the estate of the minor. Only the legal guardian of the minor can exercise any rights given to a minor.

D Signatures

I, the undersigned, agree the information provided on this form is true, complete and correctly recorded to the best of my knowledge and belief.

Signature of Certificateowner: _____

Printed name: _____

Title *(Required when applicable):* _____

Printed name of Corporation/Partnership/Trust *(If applicable):* _____

Date: m m / d d / y y y y

MassMutual
FINANCIAL GROUP®

Massachusetts Mutual Life Insurance Company US Insurance* Privacy Notice

At Massachusetts Mutual Life Insurance Company ("MassMutual") we recognize that our relationships with you are based on integrity and trust. As part of that trust relationship, we want you to understand that in order to provide our products and services to you, we must collect, use and share personal information about you. This Privacy Notice describes policies and practices about how we protect, collect and share personal information related to the products and services you receive from us, including life insurance, disability income insurance, long-term care insurance, and individual annuities. It also describes how you can limit some of that sharing.

We Protect Your Personal Information By:

- Using security measures that include physical, electronic and procedural safeguards to protect your personal information from unauthorized access or use in accordance with state and federal requirements.
- Training employees to safeguard personal information and restricting access to personal information to those employees who need it to perform their job functions.
- Contractually requiring business partners with whom we share your personal information to safeguard it and use it exclusively for the purpose for which it was shared.

Personal Information We May Collect:

The types of personal information we may collect depend on the type of product or service you have with us and may include:

- Information that you provide to us on applications or forms, during conversations with us or our representatives, or when you visit our website (for example, your name, address, Social Security number, date of birth, income, and assets, beneficiaries, and medical or health information).
- Information about your transactions with us and our affiliates, including your policy coverages, premiums, and payment history.
- Information from third parties such as consumer or other reporting agencies and medical or health care providers.

We May Share All of the Personal Information We Collect, as Described Above, 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 that market our products and services to you;
- Companies that perform marketing or administrative services for us;
- 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 policy or contract;
- Courts and government agencies in response to court orders or legal investigations;
- Credit bureaus; and
- Other financial institutions with whom we may jointly market products, if permitted in your state.

In addition, we may share certain of your personal information with your MassMutual financial professional, if he or she is a career agent of ours who terminates their relationship with us to join another financial institution (whom we call a "departing MassMutual financial professional") so that he or she can continue to work with you at his or her new company.

Please note that any personal information consisting of medical or health information is only shared with third parties to perform business, professional or insurance functions on our behalf or as authorized by you.

Important Privacy Choices

MassMutual respects your privacy choices. If you have a relationship with a departing MassMutual financial professional, as described above, and you prefer that we do not share your personal information, such as information about your insurance policies or contracts held with us, with him or her under these circumstances, you can opt out of this sharing by directing us not to do so. If you wish to opt out of the sharing of your personal information with your departing MassMutual financial professional you may:

- Call us at (800) 272-2216

You may make this privacy choice and contact us at any time, however, if we do not hear from you we may share your information with your departing MassMutual financial professional as described above. If this is a joint account, if one joint owner tells us not to share information that choice will apply to the other owner or owners. If you have already told us your choice, there is no need to do so again.

If you have not purchased a product or service through a MassMutual financial professional or you do not have a relationship with a MassMutual financial professional, as described above, you do not need to contact us as we will not share your personal information other than as described in this notice.

Other than as described above, we will only share your personal information as permitted by law and, if the law requires us to obtain your consent or give you the opportunity to opt out of some types of sharing, we will do so before sharing the information.

Certain state laws may provide residents with additional protections for personal information. If you are a resident of one of the states listed below, we will not share your personal information with your departing MassMutual financial professional unless we receive your express consent.

Arizona	Massachusetts	North Carolina
California	Minnesota	North Dakota
Connecticut	Montana	Ohio
Georgia	Nevada	Oregon
Illinois	New Jersey	Vermont
Maine	New Mexico	Virginia

If you are no longer our customer, we may continue to share your personal information as described in this Privacy Notice.

If you have any questions or concerns about this Privacy Notice, please contact us at (800) 272-2216.

* MassMutual Financial Group is a marketing name for Massachusetts Mutual Life Insurance Company (MassMutual) and its affiliated companies and sales representatives. This Privacy Notice is being provided on behalf of the following insurance companies in the MassMutual Financial Group with regard to their individual insurance business:

Massachusetts Mutual Life Insurance Company • C.M. Life Insurance Company • MML Bay State Life Insurance Company

MassMutual
FINANCIAL GROUP℠

Massachusetts Mutual Life Insurance Company
and affiliated companies
Springfield MA 01111-0001

NOTICE OF INFORMATION PRACTICES

Collection of Information

In order to underwrite and administer your insurance coverage, we, the Massachusetts Mutual Life Insurance Company, or its Affiliated MML Insurance Company to whom you are applying to for insurance, must collect a certain amount of necessary and helpful information. The amount and type of information collected may vary depending upon the amount and type of coverage applied for. In general, we will be seeking information about your age, occupation, finances, physical condition, health history, mode of living, avocations, and other personal characteristics. In addition, your agent may aid in the collection of this information and collect information to update and improve your insurance program.

Sources of Information

You are our most important source of information. We may also collect or verify information by contacting medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employer and business associates, family, friends and neighbors, and other insurance companies to which you have applied. We may collect information by exchanges of correspondence, by telephone, and by personal contact. In some cases we may ask an insurance support organization to collect information and submit an investigative consumer report to us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

Disclosure of Information

Any information obtained will be treated confidentially. Under some circumstances we, or your agent, may make disclosures of personal information, without your authorization, to third parties. Some of the persons or organizations to whom certain items of information may be disclosed are as follows:

- Persons or organizations which perform business, professional, or insurance functions for us;
- Your agent, General Agent, consumer reporting agencies hired to prepare investigative reports, and other insurance companies to which you have applied for coverage or benefits;
- Your attending physician or treating medical professional.

A description of the circumstances under which information about you might be disclosed without your authorization to the types of persons and organizations referred to above will be sent to you upon request.

Access to and Correction of Information

You have a right to learn the nature and substance of any personal information about you in our files upon written request. Should you feel any information we have in our files is inaccurate, incomplete or irrelevant, you may request correction, amendment, or deletion of that information. A description of access and correction procedures will be sent to you upon your request.

Should you have any questions about the above or about our information practices please contact the Underwriting Department.