



Adult Form

Application Part 2 (A50CA) - California Version

This application may be completed for all products when the Proposed Insured's insurance age is 16 years or older. (Use Juvenile Form Part 2, A55CA, for ages 0 through 15.)

Contents

Part 2 of Application:

- *For use by an Authorized Agent with Non-Medical Privilege*
- *For use by an Authorized Examiner*

See additional information on reverse side

There is a direct relationship between providing complete and accurate medical history and facilitating the underwriting and issue cycle so that clients receive the best possible service.

Avoid The Common Reasons For Delays In Processing

1. If amount limits, underwriting requirements, etc. qualify the Proposed Insured non-medically, **do not** have the client examined.
2. Answer all questions completely -
 - Ensure that all required questions are answered. Don't skip any "yes / no" questions.
 - Fully describe all medical history and findings.
 - A history should be described thoroughly but concisely so that the "who, what, when and why" are clear to the reader.
 - When the Proposed Insured is unclear as to the specifics, try to include as much information as possible, particularly as to the relevant dates, names and addresses of physicians, hospitals, etc.
 - In "Explanatory Details and Remarks," reference to the precise "Question Number" is important. For example, if reference is to a question with more than one part, do not enter the Question Number as "5"; use "5c" even though it may seem obvious which part of the question is being referred to.
3. Ensure that all necessary signatures have been obtained (Proposed Insured, Witness, Examiner) and, where forms require dating, the dates have been included.

General Instructions

Medical

- When scheduling an exam, furnish the client with the name of the soliciting agent, agency name and number, and the total amount of insurance applied for so this information may be included by the examiner at the bottom of page 3.
- If an examiner has not previously been authorized by the Home Office, authorization should be obtained from the Medical Examiner's Section of New Business before the exam is performed. Form M1300, *Explanation of Using Unauthorized Examiner*, should also be completed.

Non-medical

- If the Proposed Insured is a member of the agent's immediate family, the "Witness" area of the Part 2 is to be signed by the agent and either the General Agent or the authorized Manager.

Medical History

Complete 29 Below For Each Medical History Checked in 12 - 27

For Questions 12 - 27, have you ever been advised of, treated for, or had any known indication of:

<p>12. ASTHMA OR BRONCHITIS <input type="checkbox"/> Not Applicable Type: a - <input type="checkbox"/> Asthma b - <input type="checkbox"/> Bronchitis c - <input type="checkbox"/> Chronic Bronchitis d - <input type="checkbox"/> Other _____ (specify) Yes No <input type="checkbox"/> <input type="checkbox"/> Wheezing between acute attacks? <input type="checkbox"/> <input type="checkbox"/> Are the symptoms continuing?</p>	<p>14. ULCER <input type="checkbox"/> Not Applicable Type: a - <input type="checkbox"/> Duodenal b - <input type="checkbox"/> Gastric (stomach) c - <input type="checkbox"/> Other _____ (specify) Yes No <input type="checkbox"/> <input type="checkbox"/> Have you had a bleeding ulcer? <input type="checkbox"/> <input type="checkbox"/> Do you now have symptoms? <input type="checkbox"/> <input type="checkbox"/> Was surgery required?</p>	<p>16. CYSTS <input type="checkbox"/> Not Applicable a - Type: _____ (specify) <input type="radio"/> Check here if removed Pathology: <input type="checkbox"/> Benign (non cancerous) <input type="checkbox"/> Malignant (cancerous)</p>
<p>13. ARTHRITIS <input type="checkbox"/> Not Applicable Type: a - <input type="checkbox"/> Degenerative / Osteoarthritis b - <input type="checkbox"/> Rheumatoid c - <input type="checkbox"/> Gouty d - <input type="checkbox"/> Other _____ (specify) Bones or joints involved _____</p>	<p>15. COLITIS OR ILEITIS <input type="checkbox"/> Not Applicable Type: a - <input type="checkbox"/> Spastic or Mucous Colitis b - <input type="checkbox"/> Ulcerative Colitis c - <input type="checkbox"/> Crohn's Disease (Ileitis) d - <input type="checkbox"/> Other _____ (specify) Yes No <input type="checkbox"/> <input type="checkbox"/> Was there associated bleeding? <input type="checkbox"/> <input type="checkbox"/> Do you now have symptoms?</p>	<p>b - Type: _____ (specify) <input type="radio"/> Check here if removed Pathology: <input type="checkbox"/> Benign (non cancerous) <input type="checkbox"/> Malignant (cancerous)</p>

<p>17. Disorder of:</p>				
a- <input type="checkbox"/> Eyes	b- <input type="checkbox"/> Ears	c- <input type="checkbox"/> Nose	d- <input type="checkbox"/> Throat	e- <input type="checkbox"/> None of These
18. a- <input type="checkbox"/> Spine	c- <input type="checkbox"/> Back	e- <input type="checkbox"/> Muscles	g- <input type="checkbox"/> Joints	h- <input type="checkbox"/> None of These
b- <input type="checkbox"/> Bones	d- <input type="checkbox"/> Neck	f- <input type="checkbox"/> Nerves (incl. Neuritis)		
19. a- <input type="checkbox"/> Fainting	c- <input type="checkbox"/> Convulsions	e- <input type="checkbox"/> Recurrent Headache	g- <input type="checkbox"/> Nervous Disorder	i- <input type="checkbox"/> None of These
b- <input type="checkbox"/> Dizziness	d- <input type="checkbox"/> Paralysis	f- <input type="checkbox"/> Stroke	h- <input type="checkbox"/> Mental Disorder	
20. a- <input type="checkbox"/> Pneumonia	d- <input type="checkbox"/> Pleurisy	g- <input type="checkbox"/> Persistent Hoarseness		
b- <input type="checkbox"/> Emphysema	e- <input type="checkbox"/> Shortness of Breath	h- <input type="checkbox"/> Chronic Respiratory Disorder		
c- <input type="checkbox"/> Tuberculosis	f- <input type="checkbox"/> Persistent Cough			
21. a- <input type="checkbox"/> High Blood Pressure	c- <input type="checkbox"/> Heart Murmur	e- <input type="checkbox"/> Heart Attack	g- <input type="checkbox"/> Blood Vessel Disorder	
b- <input type="checkbox"/> Rheumatic Fever	d- <input type="checkbox"/> Palpitation	f- <input type="checkbox"/> Chest Pain	h- <input type="checkbox"/> Heart Disorder	i- <input type="checkbox"/> None of These
22. a- <input type="checkbox"/> Hemorrhoids	d- <input type="checkbox"/> Anorexia Nervosa	g- <input type="checkbox"/> Recurrent Indigestion	j- <input type="checkbox"/> Intestinal Disorder	
b- <input type="checkbox"/> Hepatitis	e- <input type="checkbox"/> Bulimia	h- <input type="checkbox"/> Stomach Disorder	k- <input type="checkbox"/> Gallbladder Disorder	
c- <input type="checkbox"/> Diverticulitis	f- <input type="checkbox"/> Liver Disorder	i- <input type="checkbox"/> Recurrent Diarrhea	l- <input type="checkbox"/> Intestinal Bleeding	m- <input type="checkbox"/> None of These
23. a- <input type="checkbox"/> Kidney Stone	d- <input type="checkbox"/> Sugar in Urine	g- <input type="checkbox"/> Kidney Disorder	i- <input type="checkbox"/> Pus in Urine	
b- <input type="checkbox"/> Albumin in Urine	e- <input type="checkbox"/> Prostate Disorder	h- <input type="checkbox"/> Reproductive System Disorder	j- <input type="checkbox"/> Sexually Transmitted Disease	k- <input type="checkbox"/> None of These
c- <input type="checkbox"/> Blood in Urine	f- <input type="checkbox"/> Bladder Disorder			
24. a- <input type="checkbox"/> Diabetes	b- <input type="checkbox"/> Thyroid Disorder	c- <input type="checkbox"/> Endocrine (glandular) Disorder	d- <input type="checkbox"/> None of These	
25. a- <input type="checkbox"/> Allergies	c- <input type="checkbox"/> Leukemia	e- <input type="checkbox"/> Congenital Disorder		
b- <input type="checkbox"/> Anemia	d- <input type="checkbox"/> Blood Disorder (excluding HIV)	f- <input type="checkbox"/> Recurrent Infections		g- <input type="checkbox"/> None of These
26. a- <input type="checkbox"/> Sciatica	c- <input type="checkbox"/> Lameness	e- <input type="checkbox"/> Amputation		
b- <input type="checkbox"/> Gout	d- <input type="checkbox"/> Deformity	f- <input type="checkbox"/> Speech Defect	g- <input type="checkbox"/> None of These	
27. a- <input type="checkbox"/> Skin Cancer	c- <input type="checkbox"/> Cancer	e- <input type="checkbox"/> Tumor		
b- <input type="checkbox"/> Fibroids	d- <input type="checkbox"/> Skin Disorder	f- <input type="checkbox"/> Lymph Gland Disorder		g- <input type="checkbox"/> None of These

Other Medical Information and Details

28. Other than previously stated in this application, within the last five years have you:

	Yes	No
a. Had any mental or physical disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had a consultation, surgery, or injury requiring treatment by a physician, hospital or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
c. Had any electrocardiogram, x-ray or other diagnostic test (excluding HIV test)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Been advised to have medical treatment, diagnostic tests (excluding HIV test), hospitalization or surgery which was not completed; or are you now planning to seek such advice or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
e. Been, or are you currently, under treatment or taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>

For each item checked "Yes," enter details in 29.

COMPLETE 29 FOR EACH APPROPRIATE ITEM CHECKED IN 12 - 28 ABOVE

29. Explanatory Details and Remarks for Medical History (Use form A51 for additional histories).

A.Ques. No.	Diagnosis	Medication/ Treatment	Still Under Treatment	#of Attacks/ Occurrences	Dates (mo/yr) Onset	Recovery
	-----	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician / Medical Facility Name		Address		ZIP		
-----		-----		-----		
B.Ques. No.	Diagnosis	Medication/ Treatment	Still Under Treatment	#of Attacks/ Occurrences	Dates (mo/yr) Onset	Recovery
	-----	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician / Medical Facility Name		Address		ZIP		
-----		-----		-----		
C.Ques. No.	Diagnosis	Medication/ Treatment	Still Under Treatment	#of Attacks/ Occurrences	Dates (mo/yr) Onset	Recovery
	-----	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician / Medical Facility Name		Address		ZIP		
-----		-----		-----		
D.Ques. No.	Diagnosis	Medication/ Treatment	Still Under Treatment	#of Attacks/ Occurrences	Dates (mo/yr) Onset	Recovery
	-----	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician / Medical Facility Name		Address		ZIP		
-----		-----		-----		

30. Personal Physician Information

- a. Name / Address given in: 29A 29B 29C 29D
 Have no personal physician
 Other - give Personal Physician Name / Address here:

Physician Name _____

Address _____

City _____ State _____ ZIP _____

- b. Reason you last consulted this physician
 As indicated in: 29A 29B 29C 29D
 Routine or General Exam - all findings normal
 Other - give details here:

Date Last Seen _____

Diagnosis or Reason Last Seen _____

Medication/ Treatment _____

Agreement and Signatures

I agree that: (1) this application consists of Parts 1 and 2 and any amendments and supplements which shall be attached to the policy if issued and (2) no knowledge on the part of any agent, medical examiner or any other person as to any facts pertaining to me shall be considered as having been made to or brought to the knowledge of the Company unless stated in either Part 1 or part 2 of this application or any amendments or supplements. To the best of my knowledge and belief, all information is complete and true and was correctly recorded before I signed my name below.

Signed at _____ city _____ state _____ on _____ date _____, 19 _____

Witness _____ Medical Examiner - or Agent if Non-Medical Proposed Insured _____

A50CA197

Amount Applied For \$ _____ Agency Name _____ Agency No. _____ Printed Name of Agent _____

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY and
AFFILIATED INSURANCE COMPANIES
1295 State Street
Springfield, Massachusetts 01111

HIV ANTIBODY TESTING CONSENT FORM - (CA)

To determine your insurability, the insurer named above (the insurer) has requested that you provide samples of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody/antigen test that is performed is actually a series of tests done by a medically accepted procedure. These tests are extremely reliable, but in rare instances may be positive when the person is not infected with the virus (a false positive). The test may also result in a false negative, especially when the infection occurred within the previous 3 - 6 months.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions and you may wish to consider further independent testing. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. A negative test does not mean that you have not been infected with the AIDS virus, due to the 3 - 6 month incubation period, or that you cannot get the virus in the future.

You may wish to consider counseling prior to taking this test, at your own expense, to learn more about AIDS and how to protect yourself from HIV infection. You may wish to contact your personal physician if you have any questions. A list of counseling facilities is provided for your information.

You will not be notified if your test results are negative. If they are positive, your application for insurance will be declined. You are entitled to the results. A trained person (your personal physician, for example) should convey the results so that they can be clearly explained to you. Please list the name and address of your personal physician to whom you would like positive test results sent.

(Name)

(Address)

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons, in connection with insurance you have or are applying for with the insurer, the insurer may disclose test results to its affiliates, reinsurers, employees who have responsibility for making decisions regarding your application or policy, or outside counsel. Test results may be reported to a medical information exchange using strict confidentiality procedures including the use of general codes that are also used to report other diseases or conditions not related to AIDS. Other insurers may require an HIV related test in the future should they learn of a previous abnormal test. There will be no other disclosure of test results except as may be required or permitted by law or as authorized by you.

I have read and understood this Notice of HIV Antibody Testing Consent Form, have been given written material about AIDS and counseling information. I voluntarily consent to the withdrawal of blood from me by needle, the testing of the blood withdrawn and the disclosure of test results as described above. I understand I have the right to request a copy of this consent form.

No attempt to modify or amend this form will change its terms or in any way be binding upon the insurer or any of its agents or contractors. A copy of this form will be as valid as the original.

(Signature of Proposed Insured)

(Date)