

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

Personal Information

Full name: _____ Gender: Male Female

Date of birth: _____ Birth state: _____

Residential address: _____

Phone: _____ Home Work Cell

Email: _____ SSN/ITIN: _____

Type of citizenship: Resident U.S. citizen Non-resident U.S. citizen Resident alien Other: _____

Country of citizenship: _____ Type of visa: _____ Visa number: _____

How long have you lived in the U.S. on a full time basis? _____

What members of your immediate family are full time residents in the U.S. or citizens of the U.S.? _____

Type of Government ID: U.S. Driver's License Passport Other: _____

ID number: _____ State/country issued: _____

Have you used tobacco or other nicotine containing products within the last 24 months? Yes No Not sureHave you ever been convicted of a felony, or are you currently on parole or probation? Yes No Not sureHave you been found at fault in a motor vehicle accident or moving violation within the last 3 years? Yes No Not sure

Occupation & job duties: _____

Employer name: _____

Employer address: _____

Annual earned income: \$ _____ Annual unearned income: \$ _____ Net worth: \$ _____

Recent/anticipated foreign travel? *If Yes, provide details in the Notes section.* Yes No Not sureRecent/anticipated military involvement? Yes No Not sureRecent/anticipated aviation experience (e.g. pilot, student pilot, crew member)? Yes No Not sureRecent/anticipated avocation participation (e.g. extreme sports)? Yes No Not sure

Physician name: _____

Physician address: _____

Date last seen: _____ *List any prescriptions in the Notes section*Have you been treated for, or had treatment recommended by, a health professional for cancer, heart attack, heart disease, chest pain, stroke, alcohol or drug use or immune system disorder within the past two years? Yes NoHave you been admitted to a hospital or medical facility, been advised to be admitted, or had surgery performed or recommended by a health professional other than for a normal pregnancy or childbirth within the past 90 days? Yes NoDo you have medical tests or examinations scheduled in the next 90 days except for pregnancy or childbirth? Yes No

Owner Information

Full name: _____ SSN/ITIN/EIN: _____
 Date of birth/date of Trust: _____ Relationship to Insured: _____
 Residential address: _____

Beneficiary Information

Beneficiary 1	Type: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent <input type="checkbox"/> Not sure
Full name: _____	SSN/ITIN/EIN: _____
Date of birth/date of Trust: _____	Relationship to Insured: _____
Residential address: _____	
Beneficiary 2	Type: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent <input type="checkbox"/> Not sure
Full name: _____	SSN/ITIN/EIN: _____
Date of birth/date of Trust: _____	Relationship to Insured: _____
Residential address: _____	
Beneficiary 3	Type: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent <input type="checkbox"/> Not sure
Full name: _____	SSN/ITIN/EIN: _____
Date of birth/date of Trust: _____	Relationship to Insured: _____
Residential address: _____	

Other Coverage

Complete the table below if there is any other life, annuity or long term care coverage in force or applied for:

Policy # & Company	Face Amount	Product	Issue Yr.	Purpose	Status	Replace	1035x
	\$			<input type="checkbox"/> Business <input type="checkbox"/> Personal	<input type="checkbox"/> Applied for <input type="checkbox"/> Inforce	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$			<input type="checkbox"/> Business <input type="checkbox"/> Personal	<input type="checkbox"/> Applied for <input type="checkbox"/> Inforce	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Notes

For foreign travel, provide purpose of travel, family involvement, expected date of departure, and countries/cities being visited, including durations.
