

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON



NOTICE OF INFORMATION PRACTICES

To properly underwrite and administer your group coverage, we must collect a certain amount of necessary information. In general, we will be seeking information about your age, earnings, job classification, physical and mental condition, health history and other coverage; however, this information may vary depending on the amount and type of coverage applied for. The application is our most important source of information. We may collect additional information or verify application information by contacting medical professionals, health care institutions, employers and other insurers. We may also ask you to have your attending physician complete a statement.

DISCLOSURES BY LIBERTY

In general, we do not disclose personal information about you to anyone without your consent. However, to the extent necessary to conduct our business, we may share information about you without your specific authorization. Following is a brief description of some of the persons or organizations to whom certain items of information might be disclosed:

- Persons or organizations which perform professional, business or insurance functions for us;
- Other insurance companies in connection with this application or with any other application, policy or claim involving you. For example, we would share information about you with our reinsurers or with other companies that have insured you;
- Our representatives, investigators, attorneys and other persons who are or will become involved in processing your application, providing you with service, or acting upon any claim;
- Insurance-support organizations or insurers for the purpose of detecting or preventing criminal activity, fraud, misrepresentation or nondisclosure;
- Insurance regulatory authorities, governmental authorities or law enforcement agencies to protect our interests in cases of suspected fraud or illegal activities;
- Medical professionals or institutions for the purpose of verifying insurance coverage or benefits, informing an individual of a medical condition not known to the individual, or conducting an audit;
- Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations; however, you will not be individually identified in any research report and the material we provide will be returned to us or destroyed when no longer needed;
- Our affiliates for auditing or marketing purposes; and
- A group policyholder for the purpose of reporting claims experience or conducting an audit of our operations or services.

The above describes some of the disclosures which may be made, not disclosures which are always or even often made. In any event, the information disclosed will be limited to that which is reasonably necessary to accomplish the intended purpose.

HOW YOU CAN REVIEW YOUR PERSONAL INFORMATION

You have the right to review certain recorded personal information contained in our files. You must make written request and allow 30 business days for disclosure of requested information. Our practice is to disclose the requested information to a medical professional designated by you and licensed to treat the condition to which this medical information relates. However, you have the right to have that information disclosed directly to you. We will disclose mental health record information directly to you only with the approval of the qualified professional with treatment responsibility for the condition to which the information relates.

We are not required to give you access to certain types of information. This information is usually collected in connection with a claim under an insurance policy or when the possibility of a lawsuit exists.

Please see the reverse side for additional information and required signature.

ADVERSE UNDERWRITING DECISIONS

If your application for insurance is declined or if we offer to insure you at higher than standard rates or if insurance coverage is terminated, you have the right to obtain the specific reasons for this adverse underwriting decision. You also have the right to know the specific items of information that support our action. To receive this information, you must submit a written request within 90 business days from the date we mailed the notice of the adverse underwriting decision. We will respond within 21 business days of receipt of your request. At that time, we will furnish you with the specific reason for the decision and the specific items of information that support that reason. We will also give you the name and address of any source that supplied us with the information.

IF YOU DISAGREE WITH OUR RECORDS

If you disagree with our records, you have the right to request a correction, amendment or deletion of any recorded personal information by written request which tells us what is incorrect and why. After we investigate and agree to the inaccuracy, we will proceed with the requested correction, amendment or deletion and notify anyone to whom we had provided the inaccurate information of its correction.

If we disagree, we will give you our reasons for refusing your request. If you are not satisfied, you have the right to send us a concise statement of what you believe is the correct information and why you disagree which we will place in our files, send a copy of to anyone to whom we had previously provided the disclosed information and include with any future disclosure of information from your file.

YOUR PRIVACY IS OUR CONCERN

Please be assured that Liberty is committed to the careful handling of your personal information. If you wish to exercise any of the above rights or have additional questions, please write to:

*Liberty Life Assurance Company
of Boston
Group Products - Underwriting
PO Box 1525
Dover, NH 03821-1525*

Complete the following information in its entirety. Applicant must sign and return this form to Liberty. Keep a copy of this form for your records.

COMPANY ADDRESS:

Company Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

EMPLOYEE'S HOME ADDRESS:

Employee Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

Employee's Home Telephone Number: ()

I, _____, have read and understand the above information.

Applicant's Signature

Date