

Group Name and/or Number _____ Agency # _____

We hereby direct and authorize Massachusetts Mutual Life Insurance Company and its affiliated life insurance companies (Insurance Company) to process our group list bill (paper or E-Bill) as follows:

____ Suppress Bill Do not bill the client (Company/Trustee/Plan Sponsor/Individual) for premium payments due for all policies listed now or in the future on the group number referenced above.

____ Redirect Bill The client (Company/Trustee/Plan Sponsor/Individual) hereby directs the Insurance Company to redirect all group bills and associated reminder notices to the client’s representative as follows:

Billing Name: _____
Attention: _____
Billing Address: _____
City, State, Zip: _____
Email Address: _____
Relationship: _____
(E.g. Trust Officer, Third Party Administrator, Attorney, Accountant)

The client may revoke the election to suppress or redirect bills at any time by providing written notice to the Insurance Company. The Insurance Company may discontinue this service upon two months’ written notice.

The Client will notify the Insurance Company, in writing, if the Client wishes to revoke the election to redirect bills or if the Client changes the party to which bills should be redirected.

The Client requests the Insurance Company to direct correspondence, bills, and associated reminder notices to the Client (or the Client’s representative listed above) instead of the policyowner. The Client will hold harmless and indemnify the Insurance Company from any policyowner claims related to such correspondence.

The Client understands that all premium payments (other than the initial premium payment) should continue to be sent to the Insurance Company. Payment shall be received when or before premiums become due; this form does not provide any additional grace period for premium payments. If the Client has questions regarding the policies or premium billings, the Client may contact the Insurance Company Customer Service Representative at 1-800-272-2216.

No financial services representative of the Insurance Company is authorized to provide premium paying services, including, but not limited to, receiving original billing notices and collecting any premium amount (excluding an initial premium).

Client Name and Address: _____

_____ State of _____ County of _____

Signature and Title

Before me, a Notary, Public, this _____ day of _____, _____ appeared _____ and executed this document for the uses and purposes set forth.

WITNESS my hand and official seal,
(Seal)

Signature of Notary Public

Print Name

Producer’s Signature

Date