BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x 700**

Please refer to your Administration Kit for enrollment and mailing instructions

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE/FAMILY INFORMATION

Group Number-Division Number ______ Employee/Policyholder ______ Dept. ID ______

Employee Name *(Last, First, Middle)* ______ Social Security Number ______

Home Address *(Street, City, State, Zip)* ______ Telephone # ______

Gender *(M/F)* ______ Occupation or Job Title ______ Date of Birth ______ Age ______

PAYROLL TYPE: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annual Earnings $______________

Average Hours Worked ______ Date of Hire ______ or Date of Full Time Employment if different ______ Effective Date ______ State ______ Class ______ Rate Basis ______

Spouse *(Last, First, Middle)* ______ Gender *(M/F)* ______ Date of Birth ______ Age ______ No. of Dependents ______

LIFE - DISABILITY

Only elect Boston Mutual coverages made available to you through your employer.

BASIC	YES	NO	INSURANCE AMOUNT	VOLUNTARY	YES	NO	INSURANCE AMOUNT
LIFE	☐	☐	$	LIFE	☐	☐	$
AD&D	☐	☐	$	AD&D	☐	☐	$
DEPENDENT LIFE:				DEPENDENT LIFE:			
SPOUSE	☐	☐	$	SPOUSE	☐	☐	$
CHILD(REN)	☐	☐	$	CHILD(REN)	☐	☐	$
SHORT TERM DISABILITY	☐	☐	$	SHORT TERM DISABILITY	☐	☐	$
LONG TERM DISABILITY	☐	☐	$	LONG TERM DISABILITY	☐	☐	$
OTHER *(please specify coverage & amt)*				OTHER *(please specify coverage & amt)*			
DENTAL	☐	☐		DENTAL	☐	☐	
VISION	☐	☐		VISION	☐	☐	

DENTAL - VISION

Please Complete this section for Dental and/or Vision Benefits:

I am applying for: ☐ Myself ☐ Myself, Spouse ☐ Myself, Spouse, Child(ren) ☐ Myself, Child(ren)

Dependents to be covered under the dental and/or vision plan(s) *(Last Name, First)*	Gender *(M/F)*	Date of Birth	**FULL TIME STUDENT YES**	**NO**
Child 1			☐	☐
Child 2			☐	☐
Child 3 *(list additional Dependents on separate sheet)*			☐	☐

Are there any other Dental or Vision benefits available to you or your dependents? YES ☐ **NO** ☐ *If yes, please indicate provider information:*

Insurance Company ______

Insurance Company Address ______

Insured Person ______ Insurance Company Telephone ( )

BENEFICIARY

Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: *(Total Percentage of Benefit must equal 100%)* ***List Additional Beneficiaries on separate sheet***

Primary Beneficiary(ies):	**% of Benefit**	**Relationship to you**
Contingent Beneficiary(ies):		

If you designate more than one beneficiary, please be sure the total percentages of benefit equals 100%. If you do not designate a percentage payable for each beneficiary, the total proceeds payable will be divided equally among each beneficiary. If an insured dependent dies, we will pay the proceeds to you.

SIGNATURE

Employee Signature Required

I apply for the insurance for which I am now eligible (or for which I may become eligible) under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. *I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.* I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee ______________________ Date ______________

REFUSAL OF INSURANCE

Employee Name *(Last, First, Middle)*	Employer/Policyholder	Group No.

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer (or the Association with whom I am affiliated) and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

☐ All Coverages ☐ Life & AD&D ☐ Dependent Coverage ☐ STD ☐ LTD ☐ Dental ☐ Vision

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company. If I desire to participate in the dental program at a later date, additional benefit type waiting periods may apply.

Signature of Employee ______________________ SSN # ______________

Signature of Witness ______________________ Date ______________