BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x700**

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 ______ Employer/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 ______ Dare 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
LIFE	❑	❑	$ ______
AD&D	❑	❑	$ ______
DEPENDENT LIFE:			
SPOUSE	❑	❑	$ ______
CHILD(REN)	❑	❑	$ ______
SHORT TERM DISABILITY	❑	❑	$ ______
LONG TERM DISABILITY	❑	❑	$ ______
OTHER *(please specify coverage & amt.)*	______		
DENTAL	❑	❑	
VISION	❑	❑	

VOLUNTARY	YES	NO	Insurance Amount
LIFE	❑	❑	$ ______
AD&D	❑	❑	$ ______
DEPENDENT LIFE:			
SPOUSE	❑	❑	$ ______
CHILD(REN)	❑	❑	$ ______
SHORT TERM DISABILITY	❑	❑	$ ______
LONG TERM DISABILITY	❑	❑	$ ______
OTHER *(please specify coverage & amt.)*	______		
DENTAL	❑	❑	
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	Full Time Student NO
Child 1			❑	❑
Child 2			❑	❑
Child 3 *(list additional Dependents on separate sheet)*			❑	❑

Are 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):	**% of Benefit**	**Relationship to you**

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.

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ THE FRAUD NOTICES ON THE LAST PAGE

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 ______