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

120 ROYALL STREET • CANTON, MA 02021

Please refer to your Administration Kit for enrollment and mailing instructions

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE/FAMILY INFORMATION

GroupNumber-Division Number | Employer/Policyholder | Dept. ID

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

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

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

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

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)*			

BENEFICIARY

BENEFICIARY(IES) FOR LIFE AND/OR AD&D BENEFITS:

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. Please list additional beneficiaries on separate sheet.

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

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

I hereby certify that I have been given an opportunity to participate in the Group Insurance plan offered by 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 and AD&D ☐ Dependent Coverage ☐ Short Term Disability ☐ Long Term Disability

I further understand that if I desire to participate in the Plan at a later date with the respect to the coverage(s) checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee | Date

Signature of Witness | Date

NOTICE: READ BEFORE SIGNING ENROLLMENT FORM

BOSTON MUTUAL LIFE INSURANCE COMPANY REQUIRED FRAUD NOTICES
For use with Application Forms

STANDARD NOTICE:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to California residents:
For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Residents:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Notice to DC Residents:
Warning: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by an applicant.

Notice to Florida Residents:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Maine Residents:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefit.

Notice to New Jersey Residents:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oklahoma Residents:
Any person who knowingly and with intent to injure, defraud or deceive any insurers, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon Residents:
Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Notice to Puerto Rico:
Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years, if mitigating circumstances prevail, it may be reduced to a minimum of two (2) years.

Notice to Vermont:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to criminal and civil penalties.

Notice to Virginia Residents:
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Notice to Washington:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. The penalties include imprisonment, fines, and denial of insurance benefits.