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

0018930000C1 — GroupNumber-Division Number

Willingboro B.O.E. — 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

ONLY ELECT BOSTON MUTUAL COVERAGES MADE AVAILABLE TO YOU THROUGH YOUR EMPLOYER.

LIFE - DISABILITY

BASIC	YES	NO	INSURANCE AMOUNT	VOLUNTARY	YES	NO	INSURANCE AMOUNT
LIFE	☑	☐	$ 1500.00	LIFE	☐	☐	$
AD&D	☑	☐	$ 1500.00	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

EMPLOYEE SIGNATURE REQUIRED

SIGNATURE

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 ____________