BOSTON MUTUAL LIFE INSURANCE COMMANY

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

	Ammu a	GROUP BENEFITS EN	ROLLMENT FORM				
Z	11.5.100.000.000.000						
ATIC	Employer/Policyholder			De	ept. ID		
)RM	Employee Name (Last, First, Middle)			Social Se	curity Number		
INE(()			
ILY	Home Address (Street, City, State, Zip)		Telephone #				
EMPLOYEE/FAMILY INFORMATION	Gender (M/F) Occupation or Job Title	Date of Birth		, _ ,			
LOYE	Average Hours Worked Date of Hire	or Date of Full Time Employmen	nt if different Effective Date	State	Class		
EMI	Spouse (Last, First, Middle)		Gender (M/F)	Date of Birth Age	No. of Dependents		
	You Must Have Basic Coverage t	o Elect Voluntary Coverage	You Must Have Volunta	ry Coverage to Elect Depe	ndent Coverage		
	BASIC:		VOLUNTARY:				
	Group # Div	YES NO Insurance Amount	Group # Div	YES NO Ins	surance Amount		
題	LIFE & AD&D	- \$	LIFE & AD&D	- - \$,		
LIFE			SPOUSE		.		
			DEPENDENT LIFE:				
			CHILD(REN)	□ □ \$			
BENEFICIARY	Name of Your Beneficiary(ies) for L Primary Beneficiary(ies):		rcentage of Benefit must equal 1009 are of Birth Social Security #		on separate sheet onship % of Benefit		
	Contingent Beneficiary(ies):						
	If you designate more than one be payable for each beneficiary, the total proceeds to you.	eneficiary, please be sure the total plants of the proceeds payable will be divided equ	percentages of benefit equal nally among each beneficiary.	s 100%. If you do not desig If an insured dependent die	gnate a percentage s, we will pay the		
	and the second second	ACCEPTANCE OF INSURAN	CE - Employee Signature R	equired			
SIGNATURE	to my employer by the Boston Mucontribution toward the cost of the only become insured on the date I retu	om now eligible (or for which I may bece tual Life Insurance Company and a c insurance. I understand that if I an urn to active full-time work. I further n at a later date, I must furnish, at m	nuthorize deductions, if any, m disabled on the date my insu understand that if I decline in	from my earnings of the re trance would otherwise becon usurance coverage for which	equired premium ne effective, I shall I am now eligible		
	Signature of Employee			Date			
		REFUSAL OF I	NSURANCE				
Emp	loyee Name(Last, First, Middle)	Employee/Policyh	nolder	Group ì	No		
	reby certify that I have been given an action and insured by Boston Mutual L				ion with whom I am		
<i>3.</i>	☐ Basic Life & AD&D	☐ Voluntary Life	-	Dependen	nt Life		
	ther understand that if I desire to parti- isurability satisfactory to Boston Mut		respect to the coverage checked	, I must furnish, at my own	expense, evidence		
Signature of Employee			Date				
Signature of Witness			Date				

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	GROUP BENEFITS ENROLLMENT FORM						
HOL	Employer/Policyholder					Dep	ot, ID
EMPLOYEE / FAMILY INFORMATION							
	Employee Name (Last, First, Middle)					Social Sec	curity Number
	Home Address (Street, City, State, Zip)) Felephone #	
				PAYROLL 🖵	*	,	
	Gender (M/F) Occupation or Job Title	Date of Birth	Age	TYPE: 🛚	Monthly Annual	Earnings: \$ _	
	Average Hours Worked Date of Hire	or Date of Full Time Emplo	yment if different	Effective Date		State	Class
EMP	Spouse (Last, First, Middle)			Gender (M/F)	Date of Birth	Age	No. of Dependents
	You Must Have Basic Coverage to	Elect Voluntary Coverage	You Mu	st Have Volun	tary Coverage to I	lect Depen	dent Coverage
	BASIC:			NTARY:			
	Group # Div	YES NO Insurance Amoun	t Group #	£ Div.	YES	NO Insu	irance Amount
H	LIFE & AD&D	- • \$	_ LIFE &	AD&D			
11			SPOUS	E		- \$	
			DEPEN	DENT LIFE:			
			CHILD	(REN)		□ \$	
	Name of Your Beneficiary(ies) for Li	fe and/or AD&D Benefits: (Total	al Percentage of Ber	iefit must equal 10	0%) List Additional	Beneficiaries	on separate sheet
	Primary Beneficiary(ies):	Residential Address	Date of Birth	Social Security	# Tel. #	Relation	nship % of Benefit
RY							
BENEFICIARY	Contingent Beneficiary(ies):						
EH							
BEN							
_	If you designate more than one be payable for each beneficiary, the total proceeds to you.	neficiary, please be sure the to proceeds payable will be divided	tal percentages l equally among	of benefit equ each beneficiary	als 100%. If you o	do not design pendent dies	nate a percentage , we will pay the
	\mathcal{A}^{*} . \mathcal{A}^{*}	ACCEPTANCE OF INSUR	ANCE - Empl	oyee Signature	Required		
SIGNATURE	I apply for the insurance for which I at to my employer by the Boston Mut contribution toward the cost of the only become insured on the date I retuand I desire to participate in the plan Insurance Company.	ual Life Insurance Company as insurance. I understand that if rn to active full-time work. I furn	nd authorize de <i>I am disabled or</i> ther understand	ductions, if any n the date my in that if I decline	y, from my earnin esurance would othe insurance coverage	gs of the rec erwise become for which I	quired premium e effective, I shall am now eligible
SI	Signature of Employee				Date		
		REFUSAL O	F INSURANC	CE CE			
							*
Emp	loyee Name(Last, First, Middle)	Employee/Po	licyholder			Group N	0
	reby certify that I have been given an c ated) and insured by Boston Mutual Li					the Associatio	on with whom I am
J.J -	☐ Basic Life & AD&D		Life & AD&D			Dependent	: Life
	ther understand that if I desire to partic isurability satisfactory to Boston Muti		rith respect to the	e coverage check	ed, I must fürnish,	at my own e	xpense, evidence
Signature of Employee Date							
Signature of Witness				Da	te		

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	GROUP BENEFITS ENR	ROLLME	ENT FORM	[
NO	P. J. (D.I. 1.11							
IATI	Employer/Policyholder				П	Пер	ot. ID	
ORM	Employee Name (Last, First, Middle)				_ LL	Social Sec	urity Numbe	 ∋r
EMPLOYEE/FAMILY INFORMATION					()		
	Home Address (Street, City, State, Zip) Gender (M/F) Occupation or Job Title Date of Birth		PAYROLL (D Weekly □	Telepl Bi-Weekly	ione#		
				•	Annual Earnings: \$			
	Average Hours Worked Date of Hire or Date of Full Time Employment	if different	Effective Date		State		Class	
EMD	Spouse (Last, First, Middle)		Gender (MIF)	Date of Birth		Age	No. of Dep	endents
	You Must Have Basic Coverage to Elect Voluntary Coverage	You Mu	st Have Volu	ntary Coverag	e to Elect	Depen	dent Cove	erage
	BASIC:		NTARY:					
	Group # Div YES NO Insurance Amount	Group #	Di	/·	YES NO) Insu	ırance Amo	ount
LIFE	LIFE & AD&D	LIFE &	AD&D		0 0	\$		
Π		SPOUSI	E		0 0	\$		
			DENT LIFE:					
		CHILD((REN)		0 0	\$		
	Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: (Total Perce	entage of Ben	efit must equal 10	00%) List Addit	ional Bene	ficiaries (on separate	sheet
	Primary Beneficiary(ies): Residential Address Date	of Birth	Social Security	# Tel	.#	Relation	ship % of 1	Benefit
								
ΣX								
CIA	Contingent Beneficiary(ies):							
EF								
BENEFICIARY								
	If you designate more than one beneficiary, please be sure the total pe	ercentages	of benefit equ	100%. If	you do no	t design	ate a perce	entage
	payable for each beneficiary, the total proceeds payable will be divided equal proceeds to you.	lly among	each beneficiar	y. If an insure	d depende	ent dies,	we will p	ay the
		YE E I	G!	D / /				
	ACCEPTANCE OF INSURANC							
	I apply for the insurance for which I am now eligible (or for which I may become to my employer by the Boston Mutual Life Insurance Company and aut							
Æ	contribution toward the cost of the insurance. I understand that if I am	disabled on	ı the date my i	nsurance would	l otherwise	become	effective,	I shall
AT	only become insured on the date I return to active full-time work. I further us and I desire to participate in the plan at a later date, I must furnish, at my							
SIGNATURE	Insurance Company.	•	•	,	,			
<i>•</i>	Signature of Employee			Dat	e			
	REFUSAL OF IN	SURANC	Œ					
					_			
Emp	loyee NameEmployee/PolicyholeEmployee/Policyhole	lder				roup No),	
	reby certify that I have been given an opportunity to participate in the Group ated) and insured by Boston Mutual Life Insurance Company and that I have				er (or the A	ssociation	ı with whon	n I am
	☐ Basic Life & AD&D ☐ Voluntary Life 8	& AD&D			☐ Dep	endent	Life	
	ther understand that if I desire to participate in the Plan at a later date with res surability satisfactory to Boston Mutual Life Insurance Company.	spect to the	coverage check	ed, I must fur	nish, at my	own ex	pense, evic	dence
Signa	iture of Employee		Da	te				
Signature of Witness			Da	te				