GROUP INSURANCE ENROLLMENT CARD

BOSTON MUTUAL LIFE INSURANCE COMPANY • 120 ROYALL STREET • CANTON, MASSACHUSETTS 02021-9968 • 1-800-669-2668

GROUP NUMBER	DIVISION NUMBER	EMPLOYER (POLICYHOLDER) NAME

SOCIAL SECURITY NUMBER	DATE OF HIRE	EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)
___ - ___ - ____		

STATE	CLASS	SEX (M or F)	OCCUPATION OR JOB TITLE

SALARY TYPE:
☐ Hourly (40-hour week) ☐ Weekly
☐ Monthly ☐ Annual ☐ _____ EARNINGS $ _____

DATE OF BIRTH	AVG. HOURS WORKED	EFFECTIVE DATE	DEPARTMENT ID.

NAME OF BENEFICIARY:

Primary Beneficiary	Relationship
Contingent Beneficiary(ies)	Relationship

OF THE COVERAGES AVAILABLE, I ELECT(✓):

YES	NO		YES	NO		YES	NO	
☐	☐	Life	☐	☐	Weekly Disability Income	☐	☐	Dependent Life: ☐ Spouse ☐ Dependent Children ☐ Both
☐	☐	Accidental Death & Dismemberment	☐	☐	Long-Term Disability	☐	☐	Major Medical: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family
			☐	☐	Other _____			

Spouse Name _____ Spouse Birthdate _____ No. of Dependents ____

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.

DATE _____ SIGNATURE OF EMPLOYEE _____

PLEASE INDICATE AMOUNT OF INSURANCE: Life $ _____ AD&D $ _____ WDI $ _____ LTD $ _____ Other $ _____

FORM G-6-1

INSURANCE COMPANY COPY

ED. 11/87