• GROUP INSURANCE ENROLLMENT CARD •

BOSTON MUTUAL LIFE INSURANCE COMPANY • 120 ROYALL STREET - CANTON, MA 02021-9968 • 1-800-669-2668 ext.700

Group Number	Division Number	Employer *(Policyholder)* Name

Social Security Number	Date of Hire: _____ Date of full time employment if different:	Employee Name *(Last, First, Middle Initial)*
___ - __ - ____		

State	Class	Sex *(M or F)*	Occupation or Job Title	Name of Beneficiary: Primary Beneficiary	Relationship

Salary Type:	Earnings	Contingent Beneficiary *(ies)*	Relationship
❑ Hourly *(40-hour week)* ❑ Weekly ❑ Monthly ❑ Annual ❑ _____	$ _____		

Date of Birth	Avg. Hours Worked	Effective Date	Department ID

Of the Coverages Available I Elect (✓):

YES	NO		YES	NO		YES	NO	
❑	❑	Life	❑	❑	Short Term Disability	❑	❑	Dependent Life
❑	❑	Accidental Death & Dismemberment	❑	❑	Long Term Disability	❑		
			❑	❑	Other _____			

❑ Employee Only
❑ Spouse
❑ Employee & Spouse
❑ Dependent Children
❑ Employee & Children
❑ Both
❑ Employee & Family

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 $ _____ STD $ _____ LTD $ _____ Other $ _____

Form G-6-1

INSURANCE COMPANY COPY - *top copy* EMPLOYER'S COPY - *bottom copy*

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