

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

Group Number-Division Number Emple	oyer/Policyholde	r				Dept. ID	
Group Number-Division Number Employer/Policyholder Employee Name (Last, First, Middle) Home Address (Street, City, State, Zip) Gender (M/F) Occupation or Job Title PAYROLL Weekly Bi-W TYPE: Monthly Average Hours Worked Date of Hire or Date of Full Time Employment if different						Social Security Number	
Home Address (Street, City, State, Zip)					(Teleph) ope #	
Tome Address (Street, City, State, Zip)					1		
			TVPE-		Bi-Weekly Annual Earr	nings: \$	
Gender (<i>M/F</i>) Occupation or Job Title		Date of Birth	Age Age	,		5 ·	
Average Hours Worked Date of Hire	or	Date of Full Time Employmer	nt if different Effective Da	ite	State	Class Rate Basis	
Spouse (Last, First, Middle)			Gender (M/	F) Date of Birth	1	Age No. of Dependents	
ONLY ELECT BOSTO	N MUTUA	L COVERAGES MADE	E AVAILABLE TO YO	U THROUGH	I YOUR EN	APLOYER.	
BASIC	YES NO	Insurance Amount	VOLUNTARY		YES NO	Insurance Amount	
LIFE		\$	LIFE			\$	
AD&D		\$	AD&D			\$	
DEPENDENT LIFE:			DEPENDENT LIF				
SPOUSE		\$		IFE AND AD&E		\$	
CHILD(REN)		\$	CHILD(RE	,		\$	
SHORT TERM DISABILITY		\$	SHORT TERM DI			\$	
LONG TERM DISABILITY		\$	LONG TERM DIS		(t)	\$	
□ OTHER (Please specify coverage & an	ıt.)			pecify coverage O and			
BENEFICIARY(IES) FOR LIFE	AND/OR A	D&D BENEFITS: (Atta	ach Additional Benefic	iaries on a sign	ed and date	d separate sheet)	
Primary Beneficiary(ies):	Residential A		te of Birth Social Sec	Ŭ	'el. #	Relationship % of Benefit	
Contingent Beneficiary(ies):							
				·			
If you designate more than one be payable for each beneficiary, the t	eneficiary, p	lease be sure the total pe	ercentages of benefit e	quals 100%. If y	you do not	designate a percentage	
pay the proceeds to you.	-	nplete as much beneficia	1	•	an msurea a	rependent dies, we win	
		REFUSAL OI	F INSURANCE				
I hereby certify that I have been giv <i>I am affiliated)</i> and insured by Bosto	ren an opport n Mutual Lif	tunity to participate in th	e Group Insurance Plar	n offered by my l to do so with res	Employer (or spect to:	r the Association with whom	
□ All Coverages □ Life	& AD&D	Dependent Cove	erage 🛛 Short Te	erm Disability	🖵 Lon	g Term Disability	
I further understand that if I desire evidence of insurability satisfactory	to participate to Boston M	e in the Plan at a later date	e with respect to the cov		, I must furn	ish, at my own expense,	
Signature of Employee				Date			
Signature of Witness				Date			
		EMPLOYEE SIGNA	TURE REOLURED				
I apply for the insurance for which I to my employer by the Boston Mu contribution toward the cost of the <i>become insured on the date I return t</i> desire to participate in the plan at a Company.	am now elig itual Life Ins insurance. <i>I</i> o active full-ta	tible (or for which I may beco surance Company and a <i>understand that if I am c</i> <i>ime work</i> . I further under	<i>me eligible)</i> under the pro uthorize deductions, i <i>disabled on the date my i</i> rstand that if I decline i	f any, from my <i>insurance would o</i> nsurance coverag	earnings of otherwise become ge for which	the required premium ome effective, I shall only I am now eligible and I	
Signature of Employee				Da	ate		
	EMPLOYER CO		N MUTUAL COPY	PINK - EMPLOYEE (COPY	241-057 9/13	