BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x700**
120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

25472 / 52946 Group Number-Division Number

Town of Boxborough Employer/Policyholder

Employee Name *(Last, First, Middle)* _____ Social Security Number _____

Home Address *(Street, City, State, Zip)* _____ ( ) Telephone # _____

Gender *(M/F)* _____ Occupation or Job Title _____ Date of Birth _____ Age _____ Earnings: $ _____

Average Hours Worked _____ Date of Hire _____ or Date of Full Time Employment if different _____ Effective Date _____

Spouse *(Last, First, Middle)* _____ Gender *(M/F)* _____ Date of Birth _____ Age _____ No. of Dependents _____

LIFE - DISABILITY

BASIC (50% Paid by Employer)	YES	NO	Insurance Amount
LIFE (10K Active / 5K Retiree)	☐	☐	_____
LONG TERM DISABILITY	☐	☐	_____

VOLUNTARY

Note: Whole life policies available by request: Contact Jesse White @ 781-910-1438

BENEFICIARY

BENEFICIARY(IES) FOR LIFE AND/OR AD&D BENEFITS: ***(Attach Additional Beneficiaries on a signed and dated separate sheet)***

Primary Beneficiary(ies):	Residential Address	Date of Birth	Social Security #	Tel. #	Relationship	% of Benefit
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 complete as much beneficiary information as you can provide.

SIGNATURE

REFUSAL OF INSURANCE

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my 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 ❑ Basic Life ❑ Long Term Disability ❑ Whole Life

I further understand that if I desire to participate in the Plan at a later date with 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 _____

EMPLOYEE SIGNATURE REQUIRED

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 _____