GROUP INSURANCE ENROLLMENT CARD INSURANCE COMPANY 120 ROYALL STREET - CANTON, MA 02021-9968 1

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Group N				Division Number		Employer (Policyho	lder) Name		
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State	Class	S	Sex (M or F)	Date of full time em	ployment if different:		ttages must equal 100%. At nuch beneficiary information	tach additional beneficiaries on a si n as you can provide.	gned & dated separate sheet.
			Occupation or Job T	itle:	Name of Primary I	Relationship			
Salary Type: ☐ Hourly (40-hour week) ☐ Weekly				1 ,		Address			Date of Birth
☐ Monthly ☐ Annual			Earnings:		Social Security #		Tel. #	Benefit %	
Date of Birth Avg. Hours Worked				\$	Department ID	Contingent Benefic	riary		Relationship
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				U Other	Sp	ouse Name		Spouse Birthdate	No. of Dependents
expense	, evidence	of ins	urability satisfa	actory to Boston Mut	ual Life Insurance Con	npany.	-	cipate in the plan at a later date,	·
Form G-6-1					RANCE COMPANY COPY - to		EMPLOYER'S COPY - bottom copy		221-051 9/13
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