· 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 #	Date of Hire:	Employee Name *(Last, First, Middle Initial)*
State / Class / Sex *(M or F)*	Date of full time employment if different:	*Total Benefit Percentages must equal 100%. Attach additional beneficiaries on a signed & dated separate sheet. Please complete as much beneficiary information as you can provide.*
Salary Type: ❑ Hourly *(40-hour week)* ❑ Weekly ❑ Monthly ❑ Annual ❑ _____	Occupation or Job Title:	Name of Primary Beneficiary / Relationship
	Earnings: $ _____	Address / Date of Birth
Date of Birth / Avg. Hours Worked / Effective Date / Department ID		Social Security # / Tel. # / Benefit %
		Contingent Beneficiary / Relationship
		Address / Date of Birth
		Social Security # / Tel. # / Benefit %

Of the Coverages Available I Elect (✓):

YES	NO		YES	NO		YES	NO				
❑	❑	Life	❑	❑	Short Term Disability	❑	❑	Dependent Life	❑ Employee Only		
❑	❑	Accidental Death & Dismemberment	❑	❑	Long Term Disability				❑ Spouse	❑ Dependent Children	❑ Both
			❑	❑	Other _____				❑ Employee & Spouse	❑ Employee & Children	❑ 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 $ _____

· 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 #	Date of Hire:	Employee Name *(Last, First, Middle Initial)*
State / Class / Sex *(M or F)*	Date of full time employment if different:	*Total Benefit Percentages must equal 100%. Attach additional beneficiaries on a signed & dated separate sheet. Please complete as much beneficiary information as you can provide.*
Salary Type: ❑ Hourly *(40-hour week)* ❑ Weekly ❑ Monthly ❑ Annual ❑ _____	Occupation or Job Title:	Name of Primary Beneficiary / Relationship
	Earnings: $ _____	Address / Date of Birth
Date of Birth / Avg. Hours Worked / Effective Date / Department ID		Social Security # / Tel. # / Benefit %
		Contingent Beneficiary / Relationship
		Address / Date of Birth
		Social Security # / Tel. # / Benefit %

Of the Coverages Available I Elect (✓):

YES	NO		YES	NO		YES	NO				
❑	❑	Life	❑	❑	Short Term Disability	❑	❑	Dependent Life	❑ Employee Only		
❑	❑	Accidental Death & Dismemberment	❑	❑	Long Term Disability				❑ Spouse	❑ Dependent Children	❑ Both
			❑	❑	Other _____				❑ Employee & Spouse	❑ Employee & Children	❑ 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* 221-051 9/13

COVERAGE	AMOUNT OF INSURANCE/CHANGE			EMPLOYEE'S CONTRIBUTION	COVERAGE	AMOUNT OF INSURANCE/CHANGE			EMPLOYEE'S CONTRIBUTION
LIFE	DATE				LIFE	DATE			
	AMT.					AMT.			
AD&D	DATE				AD&D	DATE			
	AMT.					AMT.			
STD	DATE				STD	DATE			
	AMT.					AMT.			
LTD	DATE				LTD	DATE			
	AMT.					AMT.			
DEP. LIFE	DATE				DEP. LIFE	DATE			
	AMT.					AMT.			

DATE INSURANCE		MISCELLANEOUS
TERMINATES	REINSTATES	Medical Exam

Groupadmin@bostonmutual.com www.bostonmutual.com Fax: 781-770-0490 Phone: 1-800-669-2668 ext. 700

COVERAGE	AMOUNT OF INSURANCE/CHANGE			EMPLOYEE'S CONTRIBUTION	COVERAGE	AMOUNT OF INSURANCE/CHANGE			EMPLOYEE'S CONTRIBUTION
LIFE	DATE				LIFE	DATE			
	AMT.					AMT.			
AD&D	DATE				AD&D	DATE			
	AMT.					AMT.			
STD	DATE				STD	DATE			
	AMT.					AMT.			
LTD	DATE				LTD	DATE			
	AMT.					AMT.			
DEP. LIFE	DATE				DEP. LIFE	DATE			
	AMT.					AMT.			

DATE INSURANCE		MISCELLANEOUS
TERMINATES	REINSTATES	Medical Exam

Groupadmin@bostonmutual.com www.bostonmutual.com Fax: 781-770-0490 Phone: 1-800-669-2668 ext. 700