• 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

Salary Type:
❑ Hourly *(40-hour week)* ❑ Weekly
❑ Monthly ❑ Annual ❑ ________

Earnings
$ ________

Date of Birth	Avg. Hours Worked	Effective Date	Department ID

Name of Beneficiary:
Primary Beneficiary ________ Relationship ________

Contingent Beneficiary *(ies)* ________ Relationship ________

________ ________

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 ❑ Dependent Children ❑ Both
❑ 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 $ ________

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

DATE INSURANCE		MISCELLANEOUS
TERMINATES	REINSTATES	Medical Exam

NOTICE: READ BEFORE SIGNING ENROLLMENT FORM

Standard Notice:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to California Residents:

For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Residents:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Notice to DC Residents:

WARNING: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by an applicant.

Notice to Florida Residents:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Maine Residents:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company. Penalties include imprisonment, fines or a denial of insurance benefit.

SEE OTHER SIDE

Notice to New Jersey Residents:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oklahoma Residents:

Any person who knowingly and with intent to injure, defraud or deceive any insurers, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon Residents:

Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Puerto Rico:

Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed establishment imprisonment may be increased to a maximum of five (5) years, if mitigating circumstances prevail, it may be reduced to a minimum of two (2) years.

Notice to Vermont Residents:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to criminal and civil penalties.

Notice to Virginia Residents:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material may have violated state law.

Washington:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application of insurance may be guilty of a criminal offense under state law.