GROUP VOLUNTARY LIFE INSURANCE ENROLLMENT FORM

Employer Section

Boston Mutual Life Insurance Company
120 Royall Street • Canton, MA 02021
1-800-669-2668, Ext. 700

NEW ❑ **CHANGE ❑**

Group # _____ Division # _____
Class _____ Premium _____
State _____ Eff. Date _____

EMPLOYEE

INFORMATION

Amounts in excess of the guaranteed issue limit or enrollment forms submitted 31 days after you first become eligible are subject to medical evidence of insurability satisfactory to Boston Mutual. If necessary, please complete the Evidence of Insurability and Authorization form and return them with this enrollment form.

Employer Name	Department	Location

Social Security # / /	Employee Name *(Last, First, Middle Initial)*				
Date of Birth / /	Age	Sex *(M or F)*	Date of Hire / /	Occupation	Avg. Hours Worked

Salary $ _____ Paid: Weekly ❑ Monthly ❑ Bi-Weekly ❑ Semi-Monthly ❑ Semi-Annual ❑ Annual ❑

INSURANCE SELECTION *(complete appropriate section)*

New Insurance ❑ **OR** **Increase in Insurance ❑** **Life ❑** **AD&D ❑**

Employee Life Insurance $ _____ Current Insurance $ _____

Additional Insurance Requested $ _____

Employee AD&D Insurance $ _____ Total Requested Insurance $ _____

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

	Name	Residential Address	Date of Birth	Social Security #	Tel. #	Relationship	% of Benefit
Primary Beneficiary(ies)							
Primary Beneficiary(ies)							
Contingent Beneficiary(ies)							
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.

SPOUSE/DEPENDENT CHILDREN

INFORMATION

Spouse Insurance Yes ❑ No ❑ **Spouse Sex (M or F)** _____ **Dependent Child(ren) Insurance Yes ❑ No ❑**

Spouse Name _____ Spouse Date of Birth / /

SPOUSE INSURANCE SELECTION *(complete appropriate section)*

New Insurance ❑ **OR** **Increase in Insurance ❑** **Life ❑** **AD&D ❑**

Spouse Life Insurance $ _____ Current Insurance $ _____

Additional Insurance Requested $ _____

Spouse AD&D Insurance $ _____ Total Requested Insurance $ _____

The beneficiary for the spouse and dependent children is the employee.

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 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 / /

1 Copy – *Boston Mutual* 1 Copy – *Employee* 1 Copy – *Employer*

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