BOSTON MUTUAL LIFE INSURANCE COMPANY –1891–

Questions? Please Contact Us At:
Group Billing Department
1-800-669-2668, Ext. 700
FAX 1-781-770-0575
Email: GroupAdmin@bostonmutual.com

GROUP INSURANCE REQUEST FOR CHANGE

THIS FORM MAY BE EITHER FAXED, MAILED OR E-MAILED

SEE REVERSE SIDE FOR DETAILED INSTRUCTIONS

EMPLOYER (POLICYHOLDER) NAME:	GROUP POLICY #	DIVISION #	DEPT. I.D.	PREPARED BY (SIGNATURE/TITLE):	DATE
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REQUIRED INFORMATION				INDICATE CHANGES ONLY						COMPLETE FOR FAMILY PLAN CHANGES ONLY ***		
SOCIAL SECURITY # (SOCIAL SECURITY # IS THE CERTIFICATE #)	EMPLOYEE'S NAME (LAST, FIRST, MI)	EFF. DATE OF CHANGE	TXN*	CLASS	UNITS	OCCUPATION	SALARY TYPE **	SALARY AMOUNT	DIV.# AND/OR DEPT. I.D.	SPOUSE'S NAME (LAST, FIRST, MI)	SPOUSE DATE OF BIRTH	NO. OF DEP.

* TXN CODES: T = Termination of Coverage. R = Reinstatement of Coverage *(indicate any changes from original coverage and the reason for reinstatement).*
N = Name Change *(list new name and put former name in parentheses after it).* C = Change in Coverage: For Class Change, list new class and information used to determine class; For Occupation Change, list new occupation; For Salary Change, list new salary and type. See reverse for Dependent Life TXN Codes.

** SALARY TYPE CODES: W = Weekly M = Monthly A = Annual S = Semimonthly B = Biweekly H = Hourly.

*** See reverse side of this page for complete instructions on changes in Spouse and Dependent coverage.

REQUEST FOR CHANGE INSTRUCTIONS

New Employees: Employees need to enroll to be insured. To enroll new employees, please submit a fully completed Group Insurance Enrollment Card for each new employee. Do not report NEW employee information on a Request for Change form. Insurance for all new employees is subject to approval by Boston Mutual Life Insurance Company.

Existing Employees *(Present Insureds):* All changes to an insured employee's coverage should be reported on the reverse side of this page. DO NOT ADJUST YOUR CURRENT PREMIUM TO REFLECT THESE CHANGES. If changes are received and approved by Boston Mutual 5 days before the preparation date of your Premium Notice, the requested changes will be reflected on your bill. Any changes received and approved later than 5 days prior to the preparation date of your Premium Notice will appear on your next bill, along with any necessary premium adjustments.

This Request for Change form may be mailed with your regular premium payment to: Boston Mutual Life Ins. Co.- G, PO Box 55154, Boston, MA 02205-5154, or send under separate cover to: Boston Mutual Life Ins. Co., Group Billing Department, 120 Royall Street, Canton, MA 02021-9968.

REQUIRED INFORMATION

PLEASE PROVIDE EMPLOYEE'S CERTIFICATE NUMBER (SOCIAL SECURITY NUMBER), EMPLOYEE'S NAME, EFFECTIVE DATE OF CHANGE AND TRANSACTION CODE (TXN) FOR ANY TYPE OF CHANGE REQUESTED ON THIS FORM.

CHANGES TO INDIVIDUAL EMPLOYEE COVERAGE

TERMINATIONS. Provide "Required Information" only. *(Place T in TXN block.)*

REINSTATEMENT. Provide "Required Information". *(Place R in TXN block.)* Also indicate any changes between old and new information in the appropriate blocks.

INCLUDE THE REASON FOR THE REINSTATEMENT ON THE LINE BELOW THE INSURED'S NAME; IE.

1. Return from Layoff
   a. list actual date of return to work
   b. coverage will be effective on the date of return
2. Re-hire
   a. list actual date of re-hire
   b. employee must satisfy waiting period again
3. Electing a Previously Refused Coverage
   a. employee must provide Evidence of Insurability/Authorization
   b. coverage will not be effective until approved by BOSTON MUTUAL
4. Return from Leave of Absence where Coverage was NOT Provided
   a. list actual date of return to work
   b. employee must satisfy waiting period again

NAME CHANGE. Provide "Required Information" *(Place N in TXN block);* list new name and put former name in parentheses beside it.

CHANGE IN COVERAGE AMOUNT. Provide "Required Information" *(place C in TXN block.)* **IN ADDITION:**

For Class change, list new class and information used to determine class *(e.g., new salary, new occupation or both).*

For Salary change, list the new total salary and type.

For Occupation change, list the new occupation.

When changing the number of Units, list the NEW number of units desired. *(Additional units may be subject to approval by Boston Mutual.)*

DEPARTMENT CHANGE:

1. If employee is transferring to another department, report as a termination. (See "Terminations".)
2. If employee is transferring from another department, list both old and new department ID numbers in the "Dept. ID" block: OLD No.
   NEW No.

DEPENDENT LIFE CHANGES/ADDITIONS

Provide "Required Information" as described. Transaction codes for Dependent Life are as follows. Evidence of Insurability may be required.

D = ADD Dependent Life. If adding both spouse and dependent *(i.e., children)* coverage, list spouse name, spouse date of birth and number of dependent children. If adding spouse coverage only, leave "No. of Dep." column blank. If adding only dependent children, list number of children *(do not list spouse information).*

CD = CHANGE Dependent Life. If changing spouse coverage only, leave "No. of Dep." column blank. If changing only dependent children coverage, list number of children *(do not list spouse information).* If changing both spouse and dependent coverage, list spouse name, spouse date of birth and number of dependent children.

NOTE: If both spouse and children are insured, and employee wishes to terminate EITHER the spouse OR dependent coverage (NOT BOTH), please do the following:

1. Place CD in the TXN block.
2. For Spouse termination, place a check mark (✔) in the shaded block to the left of spouse name.
3. For Dependent termination, place a check mark (✔) in the shaded block to the left of "No. of Dep."

TD = TERMINATE ALL Dependent Life. Provide "Required Information" only. (Place TD in TXN block.) Refusal card may be required.

Comments: _____

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THIS FORM MAY BE EITHER FAXED, E-MAILED OR MAILED.

PLEASE USE THIS FORM FOR CHANGES AND REINSTATEMENTS

ENROLLMENT FORMS MUST BE SUBMITTED FOR ALL NEW ADDITIONS.