Hampshire County Election Form and Compensation Reduction Agreement

Employer _____ Social Security _____ - _____ - _____

Employee Name _____ Date of First Deduction _____

Address _____ No. of Pay Periods 10____ 12____ 24____ 26____

_____ 52____ Other____

Premium Conversion — *Per Pay Period*

Benefit		Annual Amount	Pre-Tax	After-Tax
→ Group Term Life				
Vol Group Term				
Dental				
Disability				
Other				

Payroll Authorization:

My employer is authorized to deduct premium payments from my salary or share account as billed and forward the premium amount to the appropriate insurance carrier, as shown above. Such deductions shall cease upon written notice from me cancelling this authorization or upon termination of the plan by you.

This authorization shall be null and void if the policy(ies) is/are declined or not accepted by me.

AGENT'S SIGNATURE: _____

✳ PAYOR'S SIGNATURE: _____ DATE: _____

Waiver:

I have been offered the oppurtunity to participate in this voluntary supplemental insurance benefit plan and I have declined. I understand that if I should later desire to apply, evidence of insurability may be required.

SIGNATURE: _____ DATE: _____

BOSTON MUTUAL LIFE INSURANCE COMPANY 1-800-669-2668 x 700

120 ROYALL STREET • CANTON, MA 02021

Please refer to your Administration Kit for enrollment and mailing instructions

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE/FAMILY INFORMATION

GroupNumber-Division Number | Employee/Policyholder | Dept. ID

Employee Name *(Last, First, Middle)* | Social Security Number

Home Address *(Street, City, State, Zip)* | Telephone #

Gender *(M/F)* | Occupation or Job Title | Date of Birth | Age | PAYROLL TYPE: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annual Earnings $_____

Average Hours Worked | Date of Hire | or | Date of Full Time Employment if different | Effective Date | State | Class | Rate Basis

Spouse *(Last, First, Middle)* | Gender *(M/F)* | Date of Birth | Age | No. of Dependents

LIFE - DISABILITY

ONLY ELECT BOSTON MUTUAL COVERAGES MADE AVAILABLE TO YOU THROUGH YOUR EMPLOYER.

BASIC	YES	NO	INSURANCE AMOUNT	VOLUNTARY	YES	NO	INSURANCE AMOUNT
LIFE	☐	☐	$	LIFE	☐	☐	$
AD&D	☐	☐	$	AD&D	☐	☐	$
DEPENDENT LIFE:				DEPENDENT LIFE:			
SPOUSE	☐	☐	$	SPOUSE	☐	☐	$
CHILD(REN)	☐	☐	$	CHILD(REN)	☐	☐	$
LONG TERM DISABILITY	☐	☐	$	LONG TERM DISABILITY	☐	☐	$
OTHER *(please specify coverage & amt)*				OTHER *(please specify coverage & amt)*			

BENEFICIARY

BENEFICIARY(IES) FOR LIFE AND/OR AD&D BENEFITS:

Primary Beneficiary(ies): | **% of Benefit** | **Relationship to you**

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 list additional beneficiaries on separate sheet.

SIGNATURE

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ THE FRAUD NOTICES

EMPLOYEE SIGNATURE REQUIRED

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.

Signature of Employee | Date

REFUSAL OF INSURANCE

I hereby certify that I have been given an opportunity to participate in the Group Insurance plan offered by Employer (or the Association with whom I am affiliated) and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

☐ All Coverages ☐ Life and AD&D ☐ Dependent Coverage ☐ Short Term Disability ☐ Long Term Disability

I further understand that if I desire to participate in the Plan at a later date with the respect to the coverage(s) checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee | Date

Signature of Witness | Date

HAMPSHIRE/FRANKLIN COUNTY VOLUNTARY TERM LIFE AND AD&D RATES

Must have Basic Life to sign up for Optional Life

ISSUE AGE OPTION

GUARANTEED ISSUE AMOUNTS

AGE	Under 60	60-69	70 & Over
Employee	$ 150,000	$ 50,000	$10,000
Spouse	$ 30,000	$ 20,000	Not Eligible
Dependent	$ 5,000 or $10,000		

MONTHLY PREMIUM

Age	Monthly Premium Rate per 1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	$110,000	$120,000	$130,000	$140,000	$150,000
<35	$0.10	$1.00	$2.00	$3.00	$4.00	$5.00	$6.00	$7.00	$8.00	$9.00	$10.00	$11.00	$12.00	$13.00	$14.00	$15.00
35-39	$0.13	$1.30	$2.60	$3.90	$5.20	$6.50	$7.80	$9.10	$10.40	$11.70	$13.00	$14.30	$15.60	$16.90	$18.20	$19.50
40-44	$0.19	$1.90	$3.80	$5.70	$7.60	$9.50	$11.40	$13.30	$15.20	$17.10	$19.00	$20.90	$22.80	$24.70	$26.60	$28.50
45-49	$0.28	$2.80	$5.60	$8.40	$11.20	$14.00	$16.80	$19.60	$22.40	$25.20	$28.00	$30.80	$33.60	$36.40	$39.20	$42.00
50-54	$0.45	$4.50	$9.00	$13.50	$18.00	$22.50	$27.00	$31.50	$36.00	$40.50	$45.00	$49.50	$54.00	$58.50	$63.00	$67.50
55-59	$0.73	$7.30	$14.60	$21.90	$29.20	$36.50	$43.80	$51.10	$58.40	$65.70	$73.00	$80.30	$87.60	$94.90	$102.20	$109.50
60-64	$1.05	$10.50	$21.00	$31.50	$42.00	$52.50	$63.00	$73.50	$84.00	$94.50	$105.00	$115.50	$126.00	$136.50	$147.00	$157.50
65-69	$1.74	$17.40	$34.80	$52.20	$69.60	$87.00	$104.40	$121.80	$139.20	$156.60	$174.00	$191.40	$208.80	$226.20	$243.60	$261.00
70-74	$3.08	$30.80	$61.60	$92.40	$123.20	$154.00	$184.80	$215.60	$246.40	$277.20	$308.00	$338.80	$369.60	$400.40	$431.20	$462.00
75-79	$5.34	$53.40	$106.80	$160.20	$213.60	$267.00	$320.40	$373.80	$427.20	$480.60	$534.00	$587.40	$640.80	$694.20	$747.60	$801.00

****EMPLOYEE MUST HAVE COVERAGE IN ORDER TO INSURE SPOUSE AND/OR CHILDREN****

* EMPLOYEE LIFE & AD&D = $10,000 TO A MAXIMUM OF $500,000 (NOT TO EXCEED 5 TIMES SALARY)

* SPOUSE LIFE & AD&D = $5,000 TO A MAXIMUM OF $100,000 (NOT TO EXCEED 50% OF EMPLOYEE BENEFIT)

* DEPENDENT (LIFE ONLY) = $500 or $1,000 AGE 14 DAYS TO 1 YEAR; $5,000 ($0.95/month) or $10,000 ($1.90/month) AGE 1 YEAR TO AGE 19 OR 25 IF FULL TIME STUDENT)

* DEPENDENT CHILD(REN) - (LIFE ONLY) COVERAGE ALL GUARANTEE ISSUE

*Applicants requesting insurance over the Guaranteed Issue amount will require an Evidence of Insurability Form and Authorization to release medical information. These forms need to accompany the application.

BOSTON MUTUAL LIFE INSURANCE COMPANY

[120 Royall Street • Canton, MA 02021 1-800-669-2668 Ext. 473]

STATEMENT OF INSURABILITY FORM FOR GROUP INSURANCE

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

Refer to the Group Policy for types of coverage available and eligible amounts of insurance.

PLEASE COMPLETE IN FULL

IMPORTANT
Submit with completed Enrollment form.

EMPLOYEE/EMPLOYER

Group #	Div. #	Employer/Group Name
Social Security #		Employee Name *(Last, First, Middle Initial)*
Telephone #		Address

PROPOSED INSURED(S)

Name	Relationship	Date of Birth	Height	Weight *[(if pregnant, pre-pregnancy weight)]*

REASON

NEW

- ❑ Late Applicant
- ❑ Applying for Coverage in Excess of the Guaranteed Amount
- ❑ Applying for Supplemental Coverage
- ❑ Other _____

CHANGE

- ❑ Increase in Coverage
- ❑ Adding Spouse
- ❑ Increasing Spouse
- ❑ Adding Dependent Child(ren)
- ❑ Other _____

INSURANCE

YOU	**[LIFE**	**AD&D**	**VOLUNTARY LIFE**	**VOLUNTARY AD&D]**
Current Insurance	[			]
Additional Insurance Requested	[			]
Total New Coverage	[			]

- ❑ [Short Term Disability $ _____ *Weekly Benefit*]
- ❑ [Long Term Disability $ _____ *Monthly Benefit*]
- ❑ Other $ _____

YOUR SPOUSE	**[LIFE**	**AD&D**	**VOLUNTARY LIFE**	**VOLUNTARY AD&D]**
Current Insurance	[			]
Additional Insurance Requested	[			]
Total New Coverage	[			]

- ❑ Other $ _____

EVIDENCE OF INSURABILITY

Existing Coverage	Please list all life insurance and/or annuity contacts now in-force or pending on your life				
	Name of Company *(if replacement include Policy No.)*	Life Amount	AD&D Amount	Year Issued or Pending	Do you intend to replace or change this coverage if you and your dependents are approved for the insurance applied for on this application?
					❑ YES ❑ NO
					❑ YES ❑ NO

To be Completed for ALL Proposed Insured(s) if Required by the Group Insurance Contract

1. Have you used any form of tobacco products *(cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches)* within the past 12 months? ** **Employee** ❑ YES ❑ NO **Spouse** ❑ YES ❑ NO

** ***I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted only for misstatement of age or sex.***

2. In the past [3-10 years], have ANY of the proposed insureds been diagnosed, treated, tested positive for or been given medical advice by a licensed medical professional that they had: A) sleep apnea, asthma or emphysema; B) high blood pressure, stroke chest pain, transient ischemic attack (TIA), heart or circulatory disease or disorder; C) intestinal disease or disorder or ulcer; D) diabetes; E) leukemia, cancer, tumor or malignancy; F) epilepsy, mental or nervous disease or disorder; G) kidney or genito-urinary disease or disorder; H) disorder of the back, muscles, bones or joints; I) liver disease or disorder; J) pancreatitis (new or acute); or K) thyroid disorder? ❑ YES ❑ NO
3. In the past 5 years, have ANY of the proposed insureds been treated for or been diagnosed by a licensed medical professional as having an immune deficiency disorder or AIDS (Acquired Immune Deficiency Syndrome)? ❑ YES ❑ NO
4. In the past 5 years, have ANY of the proposed insureds; 1) been hospitalized or had hospitalization recommended; 2) had a physical examination or medical test with other than normal results? ❑ YES ❑ NO
5. Within the next 2 years, do you or your spouse: A) fly, or intend to fly, as pilot or crew member; B) race or test drive any form of vehicle; C) scubadive; D) hang glide or sky dive? ❑ YES ❑ NO
6. Have ANY of the proposed insured, within the past [3-10 years], used or are they currently using or received treatment or consultation for the use of heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs or alcoholism? ❑ YES ❑ NO
7. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having memory loss? ❑ YES ❑ NO
8. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Amytrophic Lateral Sclerosis (ALS)? ❑ YES ❑ NO
9. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having autism? ❑ YES ❑ NO
10. In the past 2 years, have any of the proposed insureds been treated, examined or advised by a licensed medical professional for attempted suicide? ❑ YES ❑ NO
11. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Huntington's Chorea? ❑ YES ❑ NO

[To be Completed if Applying for Disability Insurance

12. Are ANY of the proposed insureds currently pregnant? ❑ YES ❑ NO]

Details for questions [2-12] answered "YES". Include question number. *(Attach additional details on a signed and dated separate sheet)*

Name	Medical Condition	Date(s)	Details/Treatment	Name & Address of Attending Physicians and Hospitals

AUTHORIZATION TO OBTAIN INFORMATION

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. *(formally known as Medical Information Bureau, Inc.)*, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

MIB REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

CONSUMER REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report, which may include a report from MIB, Inc. *(formerly Medical Information Bureau, Inc.)* on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

REPRESENTATIONS AND NOTICE TO APPLICANTS

I/we have read the Statement of Insurability form and represent that the statements and answers are complete and true to the best of my/our knowledge and belief. I/we agree that this form shall form the basis for and become a part of the consideration for the insurance applied for.

CAUTION: Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Proposed Insured *(Employee/Member)*	Date	Signed & Dated at *(City, State)*
Signature of Proposed Insured *(Other than Employee/Member)* *(Employee/Member if the proposed insured is under [15])*	Date	Signed & Dated at *(City, State)*

MUST BE USED WITH HIPAA FORM DESIGNATED FOR YOUR STATE

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 ROYALL STREET · CANTON, MASSACHUSETTS 02021 · 800-669-2668

Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY

(This authorization complies with the HIPAA Privacy Rule)

Name of *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

Name of Second *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *("Providers")* that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes.**

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization,** and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. **I understand that I have the right to revoke this authorization in writing,** at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient _____

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient _____

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____, the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured _____ Date _____

LTD

Hampshire County Election Form and Compensation Reduction Agreement

Employer Gateway Regional School

Employee Name _____

Address _____

_____

Social Security _____-_____-_____

Date of First Deduction _____

No. of Pay Periods 10____ 12____ 24____ 26____

52____ Other____

Premium Conversion — Per Pay Period

	Benefit		Annual Amount	Pre-Tax	After-Tax
	Group Term Life				
	Vol Group Term				
	Dental				
***	Disability				
	Other				

Payroll Authorization:

My employer is authorized to deduct premium payments from my salary or share account as billed and forward the premium amount to the appropriate insurance carrier, as shown above. Such deductions shall cease upon written notice from me cancelling this authorization or upon termination of the plan by you.

This authorization shall be null and void if the policy(ies) is/are declined or not accepted by me.

AGENT'S SIGNATURE: _____

*** PAYOR'S SIGNATURE: _____ DATE: _____

Waiver:

I have been offered the oppurtunity to participate in this voluntary supplemental insurance benefit plan and I have declined. I understand that if I should later desire to apply, evidence of insurability may be required.

SIGNATURE: _____ DATE: _____

HAMPSHIRE COUNTY GROUP INSURANCE TRUST

Long-Term Disability

Voluntary Long-Term Disability (no contribution from the member unit) is offered to employees through the convenience of payroll deduction.

- Eligibility Requirement – All actively at work benefit eligible employees working 20 hours per week may sign up for the plan
- Monthly Benefit can not exceed 50% of your salary to a max of $3,000
- Benefit Duration - Own occupation 2 Years – You are covered if you are disabled and cannot work in your occupation for the first 2 years. After that you will continue to receive benefits if you are unable to work at any occupation you are capable of by training, education, or experience
- Elimination Period is 90 Days - no coverage for the first 90 days of disability
- Full Family Integration with Social Security -Long-Term Disability benefits will be offset with benefits received from Social Security, Workers' Compensation
- Pre-Existing Exclusion 12/6/24 -Any condition you have had 12 months prior to the policy effective date will not be covered for 24 months or until you are treatment-free for 6 continuous months
- Progressive Partial – If you are partially disabled and experience a 15% reduction in pay based upon your disability you will begin to receive pro-rated benefits
- Mental Illness/Substance abuse is covered for a period of 24 months
- Survivor Benefit – 3 months of benefits will be paid to your beneficiary
- Full maternity coverage – Pregnancy is covered like any other illness
- Wavier of premium included – While you are disabled and receiving benefits, you will not be required to pay the monthly premium for your plan
- Accumulation of the elimination period – If you are disabled for less than 90 days and attempt to come back to work, you will not be required to complete a new 90 day elimination period to start receiving benefits if you return to disabled status for the same sickness/illness
- 6-month recurrent disability – If you are disabled and come back to work for less than 6 months and go back out on the same disability you will not be required to complete a new elimination period
- Cost of living freeze – If benefits received from other sources are increased, the LTD benefit will not be reduced

Please contact Jim Flynn at LifePlus Insurance Agency, Inc. with any enrollment questions.
475 School Street Suite 5
Marshfield MA 02050
James A. Flynn, LIA 781-837-9222 fax 781-837-9227
Toll Free 866 511 9222, Email jim@lpins.com

This form is for informational purposes only, please refer to the contract for specific language.

BOSTON MUTUAL LIFE INSURANCE COMPANY 1-800-669-2668 x 700

120 ROYALL STREET • CANTON, MA 02021

Please refer to your Administration Kit for enrollment and mailing instructions

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE/FAMILY INFORMATION

GroupNumber-Division Number | Employee/Policyholder | Dept. ID

Employee Name *(Last, First, Middle)* | Social Security Number

Home Address *(Street, City, State, Zip)* | Telephone #

Gender *(M/F)* | Occupation or Job Title | Date of Birth | Age | PAYROLL TYPE: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annual Earnings $_____

Average Hours Worked | Date of Hire | or | Date of Full Time Employment if different | Effective Date | State | Class | Rate Basis

Spouse *(Last, First, Middle)* | Gender *(M/F)* | Date of Birth | Age | No. of Dependents

LIFE - DISABILITY

ONLY ELECT BOSTON MUTUAL COVERAGES MADE AVAILABLE TO YOU THROUGH YOUR EMPLOYER

BASIC	YES	NO	INSURANCE AMOUNT	VOLUNTARY	YES	NO	INSURANCE AMOUNT
LIFE	☐	☐	$	LIFE	☐	☐	$
AD&D	☐	☐	$	AD&D	☐	☐	$
DEPENDENT LIFE:				DEPENDENT LIFE:			
SPOUSE	☐	☐	$	SPOUSE	☐	☐	$
CHILD(REN)	☐	☐	$	CHILD(REN)	☐	☐	$
LONG TERM DISABILITY	☐	☐	$	LONG TERM DISABILITY	☐	☐	$
OTHER *(please specify coverage & amt)*				OTHER *(please specify coverage & amt)*			

BENEFICIARY

BENEFICIARY(IES) FOR LIFE AND/OR AD&D BENEFITS:

Primary Beneficiary(ies):	% of Benefit	Relationship to you
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 list additional beneficiaries on separate sheet.

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ THE FRAUD NOTICES

SIGNATURE

EMPLOYEE SIGNATURE REQUIRED

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.

Signature of Employee | Date

REFUSAL OF INSURANCE

I hereby certify that I have been given an opportunity to participate in the Group Insurance plan offered by Employer (or the Association with whom I am affiliated) and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

☐ All Coverages ☐ Life and AD&D ☐ Dependent Coverage ☐ Short Term Disability ☐ Long Term Disability

I further understand that if I desire to participate in the Plan at a later date with the respect to the coverage(s) checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee | Date

Signature of Witness | Date

Chart of Long Term Disability Benefits with Corresponding Monthly Premium

Monthly Benefit	Age <29	30-39	40-44	45-49	50-54	55+
$500	$2.15	$3.55	$5.70	$8.35	$11.55	$14.00
$600	$2.58	$4.26	$6.84	$10.02	$13.86	$16.80
$700	$3.01	$4.97	$7.98	$11.69	$16.17	$19.60
$800	$3.44	$5.68	$9.12	$13.36	$18.48	$22.40
$900	$3.87	$6.39	$10.26	$15.03	$20.79	$25.20
$1,000	$4.30	$7.10	$11.40	$16.70	$23.10	$28.00
$1,100	$4.73	$7.81	$12.54	$18.37	$25.41	$30.80
$1,200	$5.16	$8.52	$13.68	$20.04	$27.72	$33.60
$1,300	$5.59	$9.23	$14.82	$21.71	$30.03	$36.40
$1,400	$6.02	$9.94	$15.96	$23.38	$32.34	$39.20
$1,500	$6.45	$10.65	$17.10	$25.05	$34.65	$42.00
$1,600	$6.88	$11.36	$18.24	$26.72	$36.96	$44.80
$1,700	$7.31	$12.07	$19.38	$28.39	$39.27	$47.60
$1,800	$7.74	$12.78	$20.52	$30.06	$41.58	$50.40
$1,900	$8.17	$13.49	$21.66	$31.73	$43.89	$53.20
$2,000	$8.60	$14.20	$22.80	$33.40	$46.20	$56.00
$2,100	$9.03	$14.91	$23.94	$35.07	$48.51	$58.80
$2,200	$9.46	$15.62	$25.08	$36.74	$50.82	$61.60
$2,300	$9.89	$16.33	$26.22	$38.41	$53.13	$64.40
$2,400	$10.32	$17.04	$27.36	$40.08	$55.44	$67.20
$2,500	$10.75	$17.75	$28.50	$41.75	$57.75	$70.00
$2,600	$11.18	$18.46	$29.64	$43.42	$60.06	$72.80
$2,700	$11.61	$19.17	$30.78	$45.09	$62.37	$75.60
$2,800	$12.04	$19.88	$31.92	$46.76	$64.68	$78.40
$2,900	$12.47	$20.59	$33.06	$48.43	$66.99	$81.20
$3,000	$12.90	$21.30	$34.20	$50.10	$69.30	$84.00

Monthly Benefit = 50% of Monthly Salary
Benefit offset = Full Family Intergration - Disabilty benefits will be offset by benefits received from Social Security or workers' compensatic

Questions should be directed to LifePlus Insurance Agency, Inc.
866-511-9222

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 ROYALL STREET • CANTON, MASSACHUSETTS 02021 • 800-669-2668

Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY

(This authorization complies with the HIPAA Privacy Rule.)

Name of *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

Name of Second *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *("Providers")* that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company *(BML)* and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus *(HIV)* infection, Acquired Immune Deficiency Syndrome *(AIDS)* and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes.** I also authorize the Medical Information Bureau, Inc., to provide protected health information.

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization,** and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that **I have the right to revoke this authorization in writing,** at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, hereby, designate the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative. This designation shall remain inforce for a period of 12 months following my date of death.

Signature of Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient _____

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient _____