

PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION	Employer/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 _____		
Spouse (Last, First, Middle) _____		Gender (M/F) _____	Date of Birth _____	Age _____
No. of Dependents _____				

LIFE	You Must Have Basic Coverage to Elect Voluntary Coverage				You Must Have Voluntary Coverage to Elect Dependent Coverage			
	BASIC: Group # <u>25660</u> Div. _____ YES NO Insurance Amount • City - Division - 1 ATV-C • School - Division - 1 ATV-S				VOLUNTARY: Group # <u>25660</u> Div. _____ YES NO Insurance Amount • City - Division - 4 ATV-C • School - Division - 4 ATV-S			
	LIFE & AD&D ☒ ☐ \$ <u>5,000</u>				LIFE & AD&D ☐ ☐ \$ _____			
	SPOUSE ☐ ☐ \$ _____				DEPENDENT LIFE: CHILD(REN) ☐ ☐ \$ <u>10,000</u>			

BENEFICIARY	Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: (Total Percentage of Benefit must equal 100%) List Additional Beneficiaries on separate sheet							
	Primary Beneficiary(ies):	Residential Address	Date of Birth	Social Security #	Tel. #	Relationship	% of Benefit	

	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.

ACCEPTANCE OF INSURANCE - Employee Signature Required

SIGNATURE	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

Employee Name _____ Employee/Policyholder _____ Group No. _____
(Last, First, Middle)

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my 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:

☐ Basic Life & AD&D☐ Voluntary Life & AD&D☐ Dependent Life

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage 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 _____