



PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE/FAMILY INFORMATION

Group Number-Division Number, Employer/Policyholder, Dept. ID, Employee Name, Social Security Number, Home Address, Telephone #, Gender, Occupation or Job Title, Date of Birth, Age, PAYROLL, TYPE, Earnings, Average Hours Worked, Dare of Hire, Date of Full Time Employment, Effective Date, State, Class, Rate Basis, Spouse, Gender, Date of Birth, Age, No. of Dependents

LIFE - DISABILITY

Only elect Boston Mutual coverages made available to you through your employer.

Table with columns for BASIC and VOLUNTARY coverages, YES/NO checkboxes, and Insurance Amount.

DENTAL - VISION

Please Complete this section for Dental and/or Vision Benefits:

I am applying for: Dependents to be covered under the dental and/or vision plan(s), Child 1, Child 2, Child 3, Are any other Dental or Vision benefits available to you or your dependents?, Insurance Company, Insurance Company Address, Insured Person, Insurance Company Telephone

BENEFICIARY

Name of Your Beneficiary(ies) for Life and/or AD&D Benefits, Primary 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.

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

Employee Signature Required

SIGNATURE

I apply for the insurance for which I am now eligible... Signature of Employee, Date