**BOSTON MUTUAL LIFE INSURANCE COMPANY** 1-800-669-2668 x700

**120 Royall Street • Canton, MA 02021**

*PLEASE PRINT OR TYPE*

***Please refer to your Administration Kit for enrollment and mailing instructions***

# GROUP BENEFITS ENROLLMENT FORM

## EMPLOYEE / FAMILY INFORMATION

Haverhill, City of
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**

**BASIC:**
**Group #** 25949 **Div.** 2

| | YES | NO | Insurance Amount |
|---|---|---|---|
| LIFE & AD&D | ☑ | ❑ | $ 5,000 |

**You Must Have Voluntary Coverage to Elect Dependent Coverage**

**VOLUNTARY:**
**Group #** 25949 **Div.** 8

| | YES | NO | Insurance Amount |
|---|---|---|---|
| LIFE & AD&D | ❑ | ❑ | $ _____ |
| SPOUSE | ❑ | ❑ | $ _____ |
| **DEPENDENT LIFE:** | | | |
| CHILD(REN) | ❑ | ❑ | $ _____ |

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

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 _____