GROUP VOLUNTARY LIFE INSURANCE ENROLLMENT FORM

Employer Section

Boston Mutual Life Insurance Company
120 Royall Street, Canton, MA 02021
1-800-669-2668, Ext. 700
NEW ☐ CHANGE ☐

Group # ________ Division # ________
Class ________ Premium ________
State ________ Eff. Date ________

EMPLOYEE

Information
Amounts in excess of the guaranteed issue limit or enrollment forms submitted 31 days after you first become eligible are subject to medical evidence of insurability satisfactory to Boston Mutual. Please complete the Evidence of Insurability form found on the last page of this enrollment packet and return it with this application.

Employer Name	Department	Location

Social Security # / /	Employee Name (Last, First, Middle Initial)

Date of Birth / /	Age	Sex (M or F)	Date of Hire / /	Occupation	Avg. Hours Worked

Salary $__________ Paid: Weekly ☐ Monthly ☐ Bi-Weekly ☐ Bi-Monthly ☐ Semi-Annual ☐ Annual ☐

Insurance Selection (complete appropriate section)

New Insurance ☐ **OR** **Increase in Insurance ☐** Life ☐ AD&D ☐

Employee Life Insurance $__________ Current Insurance $__________
Additional Insurance Requested $__________
Employee AD&D Insurance $__________ Total Requested Insurance $__________

Beneficiary Information

	Name of Beneficiary	Relationship	Benefit %
Primary			
Primary			
Contingent Beneficiary			
Contingent Beneficiary			

If more than one beneficiary is designated, the proceeds will be split equally unless otherwise indicated.

SPOUSE/DEPENDENT CHILDREN

Information
Spouse Insurance Yes ☐ No ☐ **Dependent Child(ren) Insurance** Yes ☐ No ☐
Spouse Name ______________________ Spouse Date of Birth / /

Spouse Insurance Selection (complete appropriate section)

New Insurance ☐ **OR** **Increase in Insurance ☐** Life ☐ AD&D ☐

Spouse Life Insurance $__________ Current Insurance $__________
Additional Insurance Requested $__________
Spouse AD&D Insurance $__________ Total Requested Insurance $__________

The beneficiary for the spouse and dependent children is the employee.

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 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 / /