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

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

26133 Group Number-Division Number | Town of Agawam 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 | 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
LIFE	☐	☐	$
AD&D	☐	☐	$
DEPENDENT LIFE:			
SPOUSE	☐	☐	$
CHILD(REN)	☐	☐	$
SHORT TERM DISABILITY	☐	☐	$
LONG TERM DISABILITY	☐	☐	$
❑ OTHER *(Please specify coverage & amt.)*			

VOLUNTARY	YES	NO	Insurance Amount
LIFE	☐	☐	$
AD&D	☐	☐	$
DEPENDENT LIFE:			
SPOUSE LIFE AND AD&D	☐	☐	$
CHILD(REN)	☐	☐	$
SHORT TERM DISABILITY	☐	☐	$
LONG TERM DISABILITY	☐	☐	$
❑ OTHER *(Please specify coverage & amt.)*			

BENEFICIARY

BENEFICIARY(IES) FOR LIFE AND/OR AD&D BENEFITS: ***(Attach Additional Beneficiaries on a signed and dated 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.

Please complete as much beneficiary information as you can provide.

REFUSAL OF INSURANCE

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:

❑ All Coverages ❑ Life & 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 respect to the coverage(s) checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

SIGNATURE

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____

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 _____