BOSTON MUTUAL LIFE INSURANCE COMPANY
120 ROYAL STREET • CANTON, MA 02021
PLEASE PRINT OR TYPE

1-800-669-2668 x 700

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 ☐ Monthly ☐ Bi-weekly ☐ Annual | Earnings

Average Hours Worked | Date of hire or date of full time employment if different | Effective Date | MA (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	VOLUNTARY	YES	NO	INSURANCE AMOUNT
LIFE	☐	☐	5,000	LIFE	☐	☐	
AD&D	☐	☐	5,000	AD&D	☐	☐	
				DEPENDENT LIFE:			
				SPOUSE	☐	☐	
				CHILD(REN)	☐	☐	

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)	**Residential Address**	**Date of Birth**	**Social Security #**	**Tel. #**	**Relationship**	**% of Benefit**

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.

SIGNATURE

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 _____

REFUSAL OF INSURANCE

I hereby certify that I have been given the opportunity to participate in the Group Insurance plan offered by 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 Coverage

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 of Employee _____ Date _____

Signature of Witness _____ Date _____