BASIC ENROLLMENT CARD

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 Royal Street • Canton, Massachusetts 02021

EMPLOYER
(Policyholder)

GROUP POLICY NUMBER **G-**

Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

AMOUNT OF INSURANCE

(Last Name, First Name, Middle Initial)

Name of Employee

Sex *M or F* ☐ Date of Birth MO DA YR

Name of Primary Beneficiary — Relation

Effective Date of Ins. — Date Employed

Name(s) of Contingent Beneficiary(ies) — Relation

DEPT. Fire ☐ Police ☐ DPW ☐
School ☐ Other _____

I apply for the insurance for which I am now eligible for 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.**

Date _____ Signature of Employee _____

GO941-22088REV. 10/88 221-040 8/03

BASIC DECLINATION FORM

I, _____ *(please print)* do not wish to enroll in the Basic Insurance Benefit.

I understand that I must prove my insurability if I wish to be covered at a later date by taking a physical examination.

DEPT: Fire ☐ Police ☐ DPW ☐ School ☐ Other _____

Signature _____

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COVERAGE	ADJUSTMENTS				Employee's Contribution	DATE INSURANCE	
LIFE	Date					Termination	Reinstated
	Amount						
AD&D	Date						
	Amount						

❑ CHANGE OF BENEFICIARY_____

Full Name of Proposed Beneficiary *Relationship* *Age*

The right is reserved to change the beneficiary hereby designated, without the consent of said beneficiary.
If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive the Insured, unless otherwise provided herein.

If no designated beneficiary survives the Insured, settlement will be made in accordance with the terms of the above Policy(ies).

❑ CHANGE NAME OF ❑ Insured from _____

❑ Beneficiary to _____

Dated _____ 20___ _____

Insured's Signature