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

Group Number-Division Number _____ 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.

SIGNATURE

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 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 _____

BOSTON MUTUAL LIFE INSURANCE COMPANY

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STATEMENT OF INSURABILITY FORM FOR GROUP INSURANCE

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

Refer to the Group Policy for types of coverage available and eligible amounts of insurance.

PLEASE COMPLETE IN FULL

IMPORTANT
Submit with completed Enrollment form.

EMPLOYEE/EMPLOYER

Group #	Div. #	Employer/Group Name
Social Security #		Employee Name *(Last, First, Middle Initial)*
Telephone #		Address

PROPOSED INSURED(S)

Name	Relationship	Date of Birth	Height	Weight *[(if pregnant, pre-pregnancy weight)]*

REASON

NEW

- ❑ Late Applicant
- ❑ Applying for Coverage in Excess of the Guaranteed Amount
- ❑ Applying for Supplemental Coverage
- ❑ Other _____

CHANGE

- ❑ Increase in Coverage
- ❑ Adding Spouse
- ❑ Increasing Spouse
- ❑ Adding Dependent Child(ren)
- ❑ Other _____

INSURANCE

YOU	[LIFE	AD&D	VOLUNTARY LIFE	VOLUNTARY AD&D]
Current Insurance	[			]
Additional Insurance Requested	[			]
Total New Coverage	[			]

- ❑ [Short Term Disability $ _____ *Weekly Benefit*]
- ❑ [Long Term Disability $ _____ *Monthly Benefit*]
- ❑ Other $ _____

YOUR SPOUSE	[LIFE	AD&D	VOLUNTARY LIFE	VOLUNTARY AD&D]
Current Insurance	[			]
Additional Insurance Requested	[			]
Total New Coverage	[			]

- ❑ Other $ _____

EVIDENCE OF INSURABILITY

Existing Coverage	Please list all life insurance and/or annuity contacts now in-force or pending on your life				
	Name of Company *(if replacement include Policy No.)*	Life Amount	AD&D Amount	Year Issued or Pending	Do you intend to replace or change this coverage if you and your dependents are approved for the insurance applied for on this application?
					❑ YES ❑ NO
					❑ YES ❑ NO

To be Completed for ALL Proposed Insured(s) if Required by the Group Insurance Contract

1. Have you used any form of tobacco products *(cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches)* within the past 12 months? ** **Employee** ❑ YES ❑ NO **Spouse** ❑ YES ❑ NO

** *I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted only for misstatement of age or sex.*

2. In the past [3-10 years], have ANY of the proposed insureds been diagnosed, treated, tested positive for or been given medical advice by a licensed medical professional that they had: A) sleep apnea, asthma or emphysema; B) high blood pressure, stroke chest pain, transient ischemic attack (TIA), heart or circulatory disease or disorder; C) intestinal disease or disorder or ulcer; D) diabetes; E) leukemia, cancer, tumor or malignancy; F) epilepsy, mental or nervous disease or disorder; G) kidney or genito-urinary disease or disorder; H) disorder of the back, muscles, bones or joints; I) liver disease or disorder; J) pancreatitis (new or acute); or K) thyroid disorder? ❑ YES ❑ NO
3. In the past 5 years, have ANY of the proposed insureds been treated for or been diagnosed by a licensed medical professional as having an immune deficiency disorder or AIDS (Acquired Immune Deficiency Syndrome)? ❑ YES ❑ NO
4. In the past 5 years, have ANY of the proposed insureds; 1) been hospitalized or had hospitalization recommended; 2) had a physical examination or medical test with other than normal results? ❑ YES ❑ NO
5. Within the next 2 years, do you or your spouse: A) fly, or intend to fly, as pilot or crew member; B) race or test drive any form of vehicle; C) scubadive; D) hang glide or sky dive? ❑ YES ❑ NO
6. Have ANY of the proposed insured, within the past [3-10 years], used or are they currently using or received treatment or consultation for the use of heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs or alcoholism? ❑ YES ❑ NO
7. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having memory loss? ❑ YES ❑ NO
8. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Amytrophic Lateral Sclerosis (ALS)? ❑ YES ❑ NO
9. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having autism? ❑ YES ❑ NO
10. In the past 2 years, have any of the proposed insureds been treated, examined or advised by a licensed medical professional for attempted suicide? ❑ YES ❑ NO
11. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Huntington's Chorea? ❑ YES ❑ NO

[To be Completed if Applying for Disability Insurance

12. Are ANY of the proposed insureds currently pregnant? ❑ YES ❑ NO]

Details for questions [2-12] answered "YES". Include question number. *(Attach additional details on a signed and dated separate sheet)*

Name	Medical Condition	Date(s)	Details/Treatment	Name & Address of Attending Physicians and Hospitals

AUTHORIZATION TO OBTAIN INFORMATION

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. *(formally known as Medical Information Bureau, Inc.)*, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

MIB REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

CONSUMER REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report, which may include a report from MIB, Inc. *(formerly Medical Information Bureau, Inc.)* on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

REPRESENTATIONS AND NOTICE TO APPLICANTS

I/we have read the Statement of Insurability form and represent that the statements and answers are complete and true to the best of my/our knowledge and belief. I/we agree that this form shall form the basis for and become a part of the consideration for the insurance applied for.

CAUTION: Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Proposed Insured *(Employee/Member)*	Date	Signed & Dated at *(City, State)*
Signature of Proposed Insured *(Other than Employee/Member)* *(Employee/Member if the proposed insured is under [15])*	Date	Signed & Dated at *(City, State)*

MUST BE USED WITH HIPAA FORM DESIGNATED FOR YOUR STATE