BOSTON MUTUAL LIFE INSURANCE COMPANY



PLEASE PRINT OR TYPE

120 Royall Street • Canton, MA 02021

CROTIN	ENTERING PI	IDOLLA	TATT DODA
GROUP B	ENDELSE	NRODERM	ENT FORM

Group Number-Division Number E	mployer/Policy	holder							Dep	t, ID
Employee Name (Last, First, Middle)								Social S	Security N	lumber
Home Address (Street, City, State, Zip)								(Telepho) ne #	
Gender (<i>M/F</i>) Occupation or Job Title			Date of Birth	Age	PAYROLL (TYPE:	□ Weekly □ Monthly	🔲 Bi-Wo 🔲 Annua	· ·	ings: \$	
Average Hours Worked Date of Hire		or Dat	te of Full Time Employmen	ut if different	Effective Date			State	Class	Rate Basis
Spouse (Last, First, Middle)					Gender (<i>M/F)</i>	Date of B	irth		Age	No. of Dependent
ONLY ELECT BOST	TON MUT	UAL C	OVERAGES MADE	E AVAILABL	E TO YOU	THROUG	GH YOU	JR EM	PLOY	ER.
BASIC	YES	NO	Insurance Amount	VOLUN	TARY		YES	NO	Ĭnsu	rance Amount
LIFE	X	D s	2,000.00	LIFE			ц П		S	Tance Trilount
AD&D	X	0\$	2,000.00	AD&D					\$	
DEPENDENT LIFE:				DEPENI	DENT LIFE:		172	=0	2=	
SPOUSE		D \$		S	SPOUSE LIFE	AND AD	xD 🗆			
CHILD(REN)	Q	5		(CHILD(REN)				\$	
SHORT TERM DISABILITY		D \$		SHORT	TERM DISAI	BILITY			\$	
long term disability	a	5		LONG T	ERM DISAB	LITY			\$	
OTHER (Please specify coverage c)	" aint_)			OTH	ER (Please specij	v coverage 🖒	init.)			
BENEFICIARY(IES) FOR LI	FE AND/O	R AD&	D BENEFITS: (Atta	ch Addition	al Beneficiar	ies on a si	med and	d datea	l separa	ate sheet)
Primary Beneficiary(ies):		ntial Addre		te of Birth	Social Security		Tel. #			hip % of Benefi
Contingent Beneficiary(ies):	benefician	v. nlease	the sure the total pe		benefit equa		lf von de		ecional	
								o not d ured de	esignat	te a percentag nt dies, we wil
If you designate more than one payable for each beneficiary, th			te as much beneficia	ary informati	on as you ca			o not d ured de	esignat	te a percentag nt dies, we wil
If you designate more than one payable for each beneficiary, th pay the proceeds to you. I hereby certify that I have been	Please given an op	comple	te as much beneficia REFUSAL OF	FINSURAN e Group Insur	on as you ca ICE rance Plan of	n provide Fered by m	y Emplo	yer (or	54	
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If you designate more than one payable for each beneficiary, th pay the proceeds to you. I hereby certify that I have been I am affiliated) and insured by Bos I All Coverages I Li I further understand that if I desi	Please given an op ston Mutual ife & AD&I ire to partici	comple portunit I Life Ins D pate in t	te as much beneficia REFUSAL OF ty to participate in the surance Company and Dependent Cove he Plan at a later date	F INSURAN F INSURAN e Group Insur d that I have erage	on as you ca ICE rance Plan of declined to d I Short Term	fered by m o so with Disability	y Emplo respect to	yer <i>(or)</i>):] Long	<i>the Assoc</i> g Term	iation with whor Disability
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