



PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE/FAMILY INFORMATION

26521 - 1

Town of North Attleboro

GroupNumber-Division Number

Employee/Policyholder

Dept. ID

Grid for Department ID digits

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

ONLY ELECT BOSTON MUTUAL COVERAGES MADE AVAILABLE TO YOU THROUGH YOUR EMPLOYER.

LIFE - DISABILITY

Table with columns for BASIC and VOLUNTARY coverages (LIFE, AD&D, DEPENDENT LIFE) and their respective insurance amounts.

BENEFICIARY(IES) FOR LIFE AND/OR AD&D BENEFITS:

BENEFICIARY

Table for beneficiary information with columns: Primary Beneficiary(ies), % of Benefit, Relationship to you.

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.

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ THE FRAUD NOTICES

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.

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

SIGNATURE

REFUSAL OF INSURANCE

I hereby certify that I have been given an 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:

- checkboxes for All Coverages, Life and 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 the 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 \_\_\_\_\_