



PLEASE PRINT OR TYPE

**GROUP BENEFITS ENROLLMENT FORM**

EMPLOYEE/FAMILY INFORMATION

**54582** **Town of Upton**

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

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

LIFE-DISABILITY

BASIC	YES	NO	INSURANCE AMOUNT	VOLUNTARY	YES	NO	INSURANCE AMOUNT
LIFE	<input type="checkbox"/>	<input type="checkbox"/>	_____	LIFE	<input type="checkbox"/>	<input type="checkbox"/>	_____
AD&D	<input type="checkbox"/>	<input type="checkbox"/>	_____	AD&D	<input type="checkbox"/>	<input type="checkbox"/>	_____
SHORT TERM DISABILITY	<input type="checkbox"/>	<input type="checkbox"/>	_____	SPOUSE	<input type="checkbox"/>	<input type="checkbox"/>	_____
				CHILD	<input type="checkbox"/>	<input type="checkbox"/>	_____
				LONG TERM DISABILITY	<input type="checkbox"/>	<input type="checkbox"/>	_____

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.

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

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:

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 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 \_\_\_\_\_