BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x700**

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

Town of Sudbury, MA
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

7/1/2025

Spouse *(Last, First, Middle)* | Gender (*M/F*) | Date of Birth | Age | No. of Dependents

LIFE

You Must Have Basic Coverage to Elect Voluntary Coverage

BASIC:
Group # 1375 **Div.** 1

	YES	NO	Insurance Amount
LIFE & AD&D	❑	❑	$ 15,000

You Must Have Voluntary Coverage to Elect Dependent Coverage

VOLUNTARY:
Group # 3125 **Div.** 1

	YES	NO	Insurance Amount
LIFE & AD&D	❑	❑	$
SPOUSE	❑	☑	$
DEPENDENT LIFE:			
CHILD(REN)	❑	☑	$

BENEFICIARY

Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: *(Total Percentage of Benefit must equal 100%)* **List Additional Beneficiaries on 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.

ACCEPTANCE OF INSURANCE - *Employee Signature Required*

SIGNATURE

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

Employee Name _____ *(Last, First, Middle)* Employee/Policyholder _____ Group No. _____

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:

❑ Basic Life & AD&D ❑ Voluntary Life & AD&D ❑ Dependent Life

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage 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 _____