

120 Royall Street · Canton, MA 02021

PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

	GROUP BENEFITS ENR	OLLMENT FORM		
Z	Town of Mansfield		Section 19 10 to 1	
EMPLOYEE / FAMILY INFORMATION	Employer/Policyholder		Dept. ID	
SMA				
FOF	Employee Name (Last, First, Middle)		Social Security Number	
XIN	Home Address (Street, City, State, Zip)		Telephone #	
M	17/10		DLL Weekly Bi-Weekly Monthly Annual Earnings: \$	
1/FA	Gender (M/F) Occupation or Job Title Date of Birth	(F) Occupation or Job Title Date of Birth Age 11712:		
OYE	Average Hours Worked Date of Hire or Date of Full Time Employment	if different Effective Date	State Class	
IPLA	C C F MUH	Gender (M/F) D	ate of Birth Age No. of Dependents	
EN	Spouse (Last, First. Middle)	Gender (AVF)	are of birth Age 150. of Dependents	
	You Must Have Basic Coverage to Elect Voluntary Coverage	You Must Have Voluntar	y Coverage to Elect Dependent Coverage	
	BASIC: 122	VOLUNTARY: Group #	00003	
	Group # 132 Div. 10 YES NO Insurance Amount	Group # Div	YES NO Insurance Amount	
E	LIFE & AD&D	LIFE & AD&D	- - \$	
LIFE		SPOUSE	s	
		DEPENDENT LIFE:		
		CHILD(REN)	s	
	Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: (Total Pere			
	Primary Beneficiary(ies): Residential Address Dan	r of Birth Social Security #	Tel. # Relationship % of Benefit	
RY				
CIA	Contingent Beneficiary(ies):			
BENEFICIARY				
BEN				
	If you designate more than one beneficiary, please be sure the total p	ercentages of benefit equal:	100%. If you do not designate a percentage	
	payable for each beneficiary, the total proceeds payable will be divided equiproceeds to you.	ally among each beneficiary.	if an insured dependent dies, we will pay the	
	ACCEPTANCE OF INSURANCE	CE - Employee Signature Re	equired	
	I apply for the insurance for which I am now eligible (or for which I may become			
(*1	to my employer by the Boston Mutual Life Insurance Company and at	thorize deductions, if any.	from my earnings of the required premium	
URE	contribution toward the cost of the insurance. I understand that if I am	a disabled on the date my insu- understand that if I decline in	rance would otherwise become effective, I shall surance coverage for which I am now eligible	
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 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 I			surability satisfactory to Boston Mutual Life	
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 and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Bos Insurance Company.				
-	Signature of Employee		Date	
	REFUSAL OF IN	SURANCE		
E.	ployee Name Employee/Policyho	older	Group No.	
	(Last, First, Middle)			
I he	ereby certify that I have been given an opportunity to participate in the Groot listed) and insured by Boston Mutual Life Insurance Company and that I have	up Insurance Plan offered by	my Employer (or the Association with whom I am	
□ Basic Life & AD&D □ Voluntary Life &			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				
BMI	-32BBass-Vol-ENR WHITE - EMPLOYER COPY YELLOW - BOSTON	MUTUAL COPY PIN	K - EMPLOYEE COPY 241-285 9/13	