



PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION
Employer/Policyholder
Employee Name (Last, First, Middle)
Home Address (Street, City, State, Zip)
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
Spouse (Last, First, Middle) Gender (M/F) Date of Birth Age No. of Dependents

Life Insurance Selection
You Must Have Basic Coverage to Elect Voluntary Coverage
You Must Have Voluntary Coverage to Elect Dependent Coverage
BASIC: Group # Div. YES NO Insurance Amount
LIFE & AD&D
VOLUNTARY: Group # Div. 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



Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY
(This authorization complies with the HIPAA Privacy Rule)

Name of (Proposed) Insured/Patient (please print)

Date of Birth

Name of Second (Proposed) Insured/Patient (please print)

Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider ("Providers") that has provided payment, treatment or services to the person named above, or on such person's behalf, to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____, the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured

Date



STATEMENT OF INSURABILITY FORM FOR GROUP INSURANCE

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

Refer to the Group Policy for types of coverage available and eligible amounts of insurance.

PLEASE COMPLETE IN FULL

IMPORTANT

EMPLOYEE/EMPLOYER

Submit with completed Enrollment form.

Group #	Div. #	Employer/Group Name
Social Security #	Employee Name <i>(Last, First, Middle Initial)</i>	
Telephone #	Address	

PROPOSED INSURED(S)

Name	Relationship	Date of Birth	Height	Weight <i>[(if pregnant, pre-pregnancy weight)]</i>

REASON

NEW

- Late Applicant
- Applying for Coverage in Excess of the Guaranteed Amount
- Applying for Supplemental Coverage
- Other _____

CHANGE

- Increase in Coverage
- Adding Spouse
- Increasing Spouse
- Adding Dependent Child(ren)
- Other _____

INSURANCE

<u>YOU</u>	<u>[LIFE]</u>	<u>AD&D</u>	<u>VOLUNTARY LIFE</u>	<u>VOLUNTARY AD&D]</u>
Current Insurance	[_____]	_____	_____	_____]
Additional Insurance Requested	[_____]	_____	_____	_____]
Total New Coverage	[_____]	_____	_____	_____]
<input type="checkbox"/> [Short Term Disability	\$ _____]			
<input type="checkbox"/> [Long Term Disability	\$ _____]		<input type="checkbox"/> Other	\$ _____
	<i>Weekly Benefit</i>			
	<i>Monthly Benefit</i>			
<u>YOUR SPOUSE</u>	<u>[LIFE]</u>	<u>AD&D</u>	<u>VOLUNTARY LIFE</u>	<u>VOLUNTARY AD&D]</u>
Current Insurance	[_____]	_____	_____	_____]
Additional Insurance Requested	[_____]	_____	_____	_____]
Total New Coverage	[_____]	_____	_____	_____]
			<input type="checkbox"/> Other	\$ _____

EVIDENCE OF INSURABILITY

Existing Coverage	Please list all life insurance and/or annuity contacts now in-force or pending on your life				
	Name of Company <i>(if replacement include Policy No.)</i>	Life Amount	AD&D Amount	Year Issued or Pending	Do you intend to replace or change this coverage if you and your dependents are approved for the insurance applied for on this application?
					<input type="checkbox"/> YES <input type="checkbox"/> NO

To be Completed for ALL Proposed Insured(s) if Required by the Group Insurance Contract

1. Have you used any form of tobacco products (*cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches*) within the past 12 months? ** **Employee** YES NO **Spouse** YES NO

** *I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted only for misstatement of age or sex.*

2. In the past [3-10 years], have ANY of the proposed insureds been diagnosed, treated, tested positive for or been given medical advice by a licensed medical professional that they had: A) sleep apnea, asthma or emphysema; B) high blood pressure, stroke chest pain, transient ischemic attack (TIA), heart or circulatory disease or disorder; C) intestinal disease or disorder or ulcer; D) diabetes; E) leukemia, cancer, tumor or malignancy; F) epilepsy, mental or nervous disease or disorder; G) kidney or genitourinary disease or disorder; H) disorder of the back, muscles, bones or joints; I) liver disease or disorder; J) pancreatitis (new or acute); or K) thyroid disorder? YES NO

3. In the past 5 years, have ANY of the proposed insureds been treated for or been diagnosed by a licensed medical professional as having an immune deficiency disorder or AIDS (Acquired Immune Deficiency Syndrome)? YES NO

4. In the past 5 years, have ANY of the proposed insureds; 1) been hospitalized or had hospitalization recommended; 2) had a physical examination or medical test with other than normal results? YES NO

5. Within the next 2 years, do you or your spouse: A) fly, or intend to fly, as pilot or crew member; B) race or test drive any form of vehicle; C) scubadive; D) hang glide or sky dive? YES NO

6. Have ANY of the proposed insured, within the past [3-10 years], used or are they currently using or received treatment or consultation for the use of heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs or alcoholism? YES NO

7. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having memory loss? YES NO

8. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Amyotrophic Lateral Sclerosis (ALS)? YES NO

9. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having autism? YES NO

10. In the past 2 years, have any of the proposed insureds been treated, examined or advised by a licensed medical professional for attempted suicide? YES NO

11. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Huntington's Chorea? YES NO

[To be Completed if Applying for Disability Insurance

12. Are ANY of the proposed insureds currently pregnant? YES NO]

Details for questions [2-12] answered "YES". Include question number. (*Attach additional details on a signed and dated separate sheet*)

Name	Medical Condition	Date(s)	Details/Treatment	Name & Address of Attending Physicians and Hospitals

AUTHORIZATION TO OBTAIN INFORMATION

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. (*formally known as Medical Information Bureau, Inc.*), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

MIB REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

CONSUMER REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report, which may include a report from MIB, Inc. (*formerly Medical Information Bureau, Inc.*) on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

REPRESENTATIONS AND NOTICE TO APPLICANTS

I/we have read the Statement of Insurability form and represent that the statements and answers are complete and true to the best of my/our knowledge and belief. I/we agree that this form shall form the basis for and become a part of the consideration for the insurance applied for.

CAUTION: Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Proposed Insured (*Employee/Member*) Date Signed & Dated at (*City, State*)

Signature of Proposed Insured (*Other than Employee/Member*) Date Signed & Dated at (*City, State*)
(*Employee/Member if the proposed insured is under [15]*)

MUST BE USED WITH HIPAA FORM DESIGNATED FOR YOUR STATE