NEW ADD

BOSTON MUTUAL LIFE INSURANCE COMPANY GROUP ACCIDENT ENROLLMENT FORM

120 Royall Street Canton, MA 02021

Proposed Insured (Employee/Member)		er)	2. □ M Gender □ F	6. Proposed Insured (d (Spouse/Domestic Partner) 7. Gender		
3. Date of Birth	4. Age	5. Phone No.	Condoi = 1	8. Date of Birth (Spous			
10. Residential Address (No P.O. Bo	x)		I			
No. Street				City	State	Zip	
11. Mailing Address (if different)					12. Social Security/ITIN (Employee/Member)		
13. Are you actively at work? □ YES □ NO	P Empl	loyer:			Date of Hire:		
14. Plan <i>(select one)</i> ☐ Employee/Member	Only			Employee/Member a	nd Children		
☐ Employee/Member	and Spous	se/Domestic Par	rtner 🗆	Employee/Member, S	Spouse/Domestic Partner and	Children	
Total Weekly Premium	\$			Plan			
5. Beneficiary					Relationship		
 Do you or any person Will this insurance rep 	olace any o	ther coverage? ((If yes, comple	te state replacement fo	r such insurance pending? Y	′ES □ NO	
 Do you or any person Will this insurance report of "YES" to #1 OR #2, Are all individuals to provides medical, how plans? (If no, individuals insurance under the 	blace any o provide na be insured spital, and	ther coverage? (ame of insurance currently coverage surgical coverage	If yes, comple company and ed by an individue not designed	te state replacement for type of insurance: dual or group policy or d to supplement other	orm if required) $\dots $	YES NO	
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