NEW ☐ ADD ☐

BOSTON MUTUAL LIFE INSURANCE COMPANY

GROUP ACCIDENT ENROLLMENT FORM

120 Royall Street
Canton, MA 02021

PART A:

1. Proposed Insured *(Employee/Member)*	2. Gender ☐ M ☐ F	6. Proposed Insured *(Spouse/Domestic Partner)*	7. Gender ☐ M ☐ F
3. Date of Birth / 4. Age / 5. Phone No. ( )		8. Date of Birth *(Spouse/Domestic Partner)* / 9. Age	

10. Residential Address *(No P.O. Box)*

No. Street City State Zip

11. Mailing Address *(if different)*	12. Social Security/ITIN *(Employee/Member)*

13. Are you actively at work? ☐ YES ☐ NO Employer: Date of Hire:

14. Plan *(select one)*

☐ Employee/Member Only
☐ Employee/Member and Children
☐ Employee/Member and Spouse/Domestic Partner
☐ Employee/Member, Spouse/Domestic Partner and Children

Total Weekly Premium $ _____ Plan _____

15. Beneficiary	Relationship

16. Other Information:

1. Do you or any person to be insured have any accident insurance or any application for such insurance pending? ☐ YES ☐ NO
2. Will this insurance replace any other coverage? *(If yes, complete state replacement form if required)* . . . . . ☐ YES ☐ NO
   If "YES" to #1 OR #2, provide name of insurance company and type of insurance: _____
3. Are all individuals to be insured currently covered by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other provider or governmental plans? *(If no, individuals that are not covered by a health plan as specified above will not be eligible for insurance under the Policy.)* ☐ YES ☐ NO

17. Special Requests

AGREEMENT AND DECLARATION - Read Carefully Before Signing

I represent that the statements and answers written in this enrollment form Part A and any supplements are complete and true to the best of my/our knowledge and belief, and it is agreed that:

A. This enrollment form and any supplement shall form the basis for and become a part of any certificate issued.

B. The agent has no authority to waive the answer to any question in or to modify the enrollment form.

C. The insurance applied for shall be in force at 11:59 PM on the date of the enrollment form signed by me, provided that the Company approved the insurance without any modification as to plan, amount of premium, and, further provided that the Company receives the first premium payment within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance will become effective.

D. The employee/member will be the owner of his/her coverage and all dependent coverage.

E. I have received a copy of Boston Mutual's Notice of Information Privacy Practices. I have received a copy of an Outline of Coverage *(where applicable)*.

F. CAUTION: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Employee/Member *(Owner)* _____

Witnessed *(Licensed Agent)* _____ NPN # _____
(please sign and print your name) *(National Producer Number)*

Dated _____ at _____
(Month, Day, Year) *(City, State)*