

BASIC ENROLLMENT CARD

BOSTON MUTUAL LIFE INSURANCE COMPANY 120 ROYAL STREET – Canton, Massachusetts 02021	EMPLOYER City of Lawrence – Lawrence Public Schools	GROUP POLICY NUMBER	G - 24299 - Div 3
Social Security Number _____			AMOUNT OF INSURANCE
(Last Name, First Name, Middle Initial)			
Name of Employee _____			
Sex Female <input type="checkbox"/> Male <input type="checkbox"/>	Date of Birth (mm/dd/yy) _____	Name of Primary Beneficiary _____	Relation _____
Effective Date of Ins. _____	Date Employed _____	Name(s) of Contingent Beneficiary(ies) _____	Relation _____
DEPT. Fire <input type="checkbox"/> Police <input type="checkbox"/> DPW <input type="checkbox"/> School <input type="checkbox"/> Other <input type="checkbox"/>			

I apply for the insurance for which I am now eligible for which I may become eligible for 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.**

Date _____ Signature of Employee _____

BASIC DECLINATION FORM

I, _____ (please print) do not wish to enroll in the Basic Insurance Benefit. I understand that I must prove my insurability if I wish to be covered at a later date by taking a physical examination.

DEPT: Fire Police DPW School Other

Signature _____

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COVERAGE	ADJUSTMENTS				Employee's Contribution	DATE INSURANCE	
LIFE	Date					Termination	Reinstated
	Amount						
AD&D	Date						
	Amount						
<input type="checkbox"/> CHANGE OF BENEFICIARY		Full Name of Proposed Beneficiary _____				Relationship	Age

The right is reserved to change the beneficiary hereby designated, without the consent of said beneficiary. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive the insured, unless provided herein. If no designated beneficiary survives the insured, settlement will be made in accordance with the term of the above Policy(ies).

CHANGE NAME OF Insured from _____
 Beneficiary to _____

Dated _____ Insured's Signature _____