120 Royall Street • Canton, MA 02021



PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

7	Town of Acushnet	ROLLWENT TORW	
TION	Employer/Policyholder		Dept. ID
RMA	Employee Name (Last, First, Middle)		Social Security Number
NFO	Employee Name (Last, 1915), Ivitaale)		()
EMPLOYEE / FAMILY INFORMATION	Home Address (Street, City, State, Zip)	PAYROLL ☐ Weekly ☐ Bi-	Telephone #
	Gender (M/F) Occupation or Job Title Date of Birth		nual Earnings: \$
	Average Hours Worked Date of Hire or Date of Full Time Employment	t if different Effective Date	State Class
EM	Spouse (Last, First, Middle)	Gender (<i>M/F</i>) Date of Birth	Age No. of Dependents
	You Must Have Basic Coverage to Elect Voluntary Coverage	You Must Have Voluntary Coverage t	o Elect Dependent Coverage
LIFE	BASIC:	VOLUNTARY:	
	Group # Div YES NO Insurance Amount	Group # Div YI	
	LIFE & AD&D \(\mathbb{A}\) \(\mathbb{I}\)	LIFE & AD&D SPOUSE	
		DEPENDENT LIFE:	
		CHILD(REN)	1 \$
	Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: (Total Per	centage of Benefit must equal 100%) List Additior	nal Beneficiaries on separate sheet
BENEFICIARY	Primary Beneficiary(ies): Residential Address Date	te of Birth Social Security # Tel. #	Relationship % of Benefit
	Contingent Beneficiary(ies):		
			1 . 1
	If you designate more than one beneficiary, please be sure the total p payable for each beneficiary, the total proceeds payable will be divided equa-	ally 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 to my employer by the Boston Mutual Life Insurance Company and au	uthorize deductions, if any, from my earr	nings of the required premium
	contribution toward the cost of the insurance. I understand that if I am only become insured on the date I return to active full-time work. I further to		
LAN:	and I desire to participate in the plan at a later date, I must furnish, at my Insurance Company.		
SIC	Signature of Employee	Date	
REFUSAL OF INSURANCE			
Employee Name Employee/Policyholder		older	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			☐ 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	

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