



PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

Employer/Policyholder: Lincoln
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

You Must Have Basic Coverage to Elect Voluntary Coverage
BASIC: Group # 2775 Div. YES NO Insurance Amount
LIFE & AD&D [X] [ ] \$ 10,000
You Must Have Voluntary Coverage to Elect Dependent Coverage
VOLUNTARY: Group # 12611 Div. YES NO Insurance Amount
LIFE & AD&D [ ] [ ] \$
SPOUSE [ ] [ ] \$
DEPENDENT LIFE: CHILD(REN) [ ] [ ] \$

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