For Your Information

30.2 Life Insurance

The Town provides two thousand ($2,000.) dollars worth of group term life insurance to all employees who work twenty (20) hours or more on a regular basis or 1040 hours per year. The Town pays 50% of the cost; the employee pays 50% of the cost. The insurance is not automatic. The insurance is not mandatory, and employees may elect to take the insurance at a cost determined by the Treasurers Office on an annual basis. The Town Administrator or the Treasurer's Office shall offer the qualified employee the insurance during employee orientation. Employees, at their option, may purchase additional insurance at 100% of the cost.

BOSTON MUTUAL LIFE INSURANCE PROGRAM
TOWN OF TOWNSEND
Benefit Summary

BASIC LIFE AND AD&D INSURANCE GROUP # G-2027 DIV 1

	Life	AD&D
Active Employees	$2,000	$2,000
Upon Retirement	$2,000	$2,000

DIV 1 Premium = $2.00/mo
NOTE: The Town pays 50% so employee only pays $1.00/mo

VOLUNTARY LIFE & AD&D INSURANCE GROUP # G-24653 DIV 1

You must be enrolled in the Basic Life Insurance to join this plan

Active Employees: Choice of $5,000 to $40,000 in increments of $5,000 (All Guaranteed Issue)

Cost: $.63 per $1,000 per month (100% employee paid)

		(Cost per month)
Active Employees:	$ 5,000	$ 3.15
	$10,000	$ 6.30
	$15,000	$ 9.45
	$20,000	$ 12.60
	$25,000	$ 15.75
	$30,000	$ 18.90
	$35,000	$ 22.05
	$40,000	$ 25.20

Dependent Life:	**Spouse:**	**$5,000**
(Employee must have voluntary coverage to elect dependent coverage)	**Children:**	
	14 days to 6 months	**$ 400**
	6 months to age 19;	**$2,000**
	(to age 25, if full-time student)	

Cost for Dependent Life coverage: $4.33 per family per month

Upon retirement, Life and Accidental Death and Dismemberment benefits reduce to $5,000.

All benefits, including dependent life, for Active employees and Retirees shall terminate at age 75. Dependent spouse coverage shall terminate at the earlier of termination of the employee's coverage, or when the dependent spouse no longer qualifies as an eligible spouse under the terms of the group policy.

Basic & Voluntary Life Insurance Includes:
Accidental Death & Dismemberment Insurance (AD&D)
Waiver of Premium
Right to Convert

The above information is a summary of benefits; this summary is not your Certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the group policy will be resolved by the language issued in the master policy. Please contact your benefits administrator for policy provisions.

BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x700**

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

Employer/Policyholder _____ Dept. ID _____

Employee Name *(Last, First, Middle)* _____ Social Security Number _____

Home Address *(Street, City, State, Zip)* _____ ( ) Telephone # _____

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 _____

LIFE

You Must Have Basic Coverage to Elect Voluntary Coverage

BASIC:

Group # _____ **Div.** _____

	YES	NO	Insurance Amount
LIFE & AD&D	❑	❑	$ _____

You Must Have Voluntary Coverage to Elect Dependent Coverage

VOLUNTARY:

Group # _____ **Div.** _____

	YES	NO	Insurance Amount
LIFE & AD&D	❑	❑	$ _____
SPOUSE	❑	❑	$ _____

DEPENDENT LIFE:

CHILD(REN)	❑	❑	$ _____

BENEFICIARY

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 _____