Group Basic Life and Accidental Death & Dismemberment Benefit Summary for Eligible Employees of Town of Framingham, MA

The following 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.

Eligibility
All Eligible Active Employees working a minimum of **20** hours per week are eligible. *If you are not actively at work on the effective date then insurance will not become effective until you return to active employment.*

Employee Basic Life and AD&D Benefit

- Flat $7,500.
- Upon retirement, Basic Life and AD&D coverage continues at $5,000.

Cost of Coverage
You, the employee, currently contribute to the cost of the Basic Group Life and AD&D coverage. Please consult your Benefits Administrator for specific contribution percentage.

Portability
If you leave your employment prior to age **60**, the coverage is "portable" for you. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium.

Conversion
Employees have 31 days from the date of termination to convert their Basic Life Insurance to an individual permanent life policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium.

Waiver of Premium
If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Boston Mutual will continue your insurance without any further payment of premiums subject to the provisions of the contract.

Accelerated Death Benefit
This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary.

Education Benefit
We will pay a percentage of an employee's life insurance benefit to a maximum of $2,500 per year, for up to four years of education, to each qualifying dependent if the employee's death is the result of an accident while covered under Group AD&D.

Seat Belt Benefit
We will pay an additional 50% of the AD&D benefit, not to exceed $10,000, in the event of an insured's death as a result of an automobile accident while wearing a properly secured seat belt.

Repatriation of Remains Benefit
If an employee dies as a result of an Accident while insured for AD&D and the death occurs outside a 100 mile radius from his or her primary residence, we will pay for Covered Expenses reasonably incurred to return his or her body to their primary residence up to $5,000.

Exclusions
Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: self-inflicted injuries, suicide or attempted suicide, riot or war, diseases, ptomaine or bacterial infection, drug and/or alcohol abuse, commission of an assault or felony by an employee, accident while serving on active duty, travel or flight in any aircraft or device which can fly above the earth's surface (does not apply to commercial flights) or injury which occurred before the Employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefit administrator.

Also available to you…

Bereavement Counseling*
This service is provided to all beneficiaries who experience the loss of a loved one. Beneficiaries have access to a toll-free counseling service supported by professional counselors experienced with the human emotions associated with the death of a loved one.

**Services provided by Health Management Systems of America – a nationally recognized leader in the field of Mental and Behavioral Health Care Services. These services are currently available but are not part of your Boston Mutual policy/contract.*

Group Voluntary Life and Accidental Death & Dismemberment Benefit Summary for Eligible Employees of Town of Framingham, MA

The following 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.

Eligibility

You as an **active full-time employee** working **20** or more hours per week, **your spouse under age 70, your unmarried children ages 14 days to 19 years (to age 25 if a full-time student), and handicapped children over the age of 19 are eligible for coverage.**

Dependents may not be insured if they are confined in a medical facility. Dependent coverage is available only if you, the employee, also elects coverage. If you are not actively at work on the effective date of coverage, then your insurance will not become effective until the date you return to active employment.

Voluntary Life and AD&D Available Benefit Amounts

- You have the flexibility to choose coverage for yourself in units of **$10,000** to a maximum of **$500,000.** However, the maximum coverage amount you may elect cannot exceed five times your base annual salary.
- You may insure your spouse in units of **$5,000** to a maximum of **$250,000**, not to exceed **50%** of your coverage amount.
- You may insure your dependent children for Life Insurance only. Coverage amounts are as follows:
  - 14 days to 1 year.....**$1,000**
  - 1 year to 19 years* .....**$5,000 or $10,000**

    *(Age 25 for full-time students)

A spouse or child who is also an employee cannot be insured as a dependent. If both spouses are insured employees of the same group, their children can be insured as dependents of one spouse only.

Medical Questions

If you and your eligible dependents enroll within the initial eligibility period as defined by the policy, you and your dependents may purchase a specific amount of insurance on a guaranteed basis. No medical questions will be asked for coverage at or under the Guarantee Issue Amount.

Guarantee Issue Amounts

Age	Employee	Spouse
Under Age 69	**$130,000**	**$30,000**
*Age 70 and over	**$0**	**-$0-**

All life coverage for dependent children is Guarantee Issue

*** Employee's insurance reduction schedule applies. Please refer to the section: Benefit Reductions**

Guarantee Issue coverage will become effective for eligible employees on the later of the effective date as defined by the group policy or the date the application is approved by Boston Mutual. Proof of good health satisfactory to Boston Mutual is required for amounts above the Guarantee Issue Amounts or beyond the initial eligibility period.

Cost of Coverage

You pay for the cost of the Group Voluntary Term Life and AD&D coverage. Below, you will find samples of **Monthly** payroll deductions for you and your spouse:

Sample Monthly Payroll Deductions

Age	Monthly Premium Rate per $1,000	10,000	30,000	50,000	100,000	130,000
<35	**$0.12**	$1.20	$3.60	$6.00	$12.00	$15.60
35-39	**$0.15**	$1.50	$4.50	$7.50	$15.00	$19.50
40-44	**$0.22**	$2.20	$6.60	$11.00	$22.00	$28.60
45-49	**$0.31**	$3.10	$9.30	$15.50	$31.00	$40.30
50-54	**$0.50**	$5.00	$15.00	$25.00	$50.00	$65.00
55-59	**$0.82**	$8.20	$24.60	$41.00	$82.00	$106.60
60-64	**$1.17**	$11.70	$35.10	$58.50	$117.00	$152.10
65-69	**$1.87**	$18.70	$56.10	$93.50	$187.00	$243.10
70-74	**$4.37**	$43.70	$131.10	$218.50	$437.00	$568.10

Premium rates for employees age 75 and above are available. Please contact your benefits administrator for details

This plan utilizes Boston Mutual's Issue Age billing option. Issue age billing means that Employees and Spouses enroll and are billed based on their age band as of the effective date of coverage. Once enrolled, Employees and Spouses remain in the age band they were originally issued at with Boston Mutual.

After the initial rate guarantee period, the group is subject to an annual review and possible rate changes.

- The cost to insure all eligible dependent children for Voluntary Life Insurance is only

  $ 0.95 for $5,000 of Family Unit Monthly

  Or

  $1.90 for $10,000 of Family Unit Monthly

See reverse side for additional information

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 _____

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 Royall Street • Canton, MA 02021 1-800-669-2668 Ext. 473

EVIDENCE OF INSURABILITY FORM FOR GROUP INSURANCE

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

Refer to the Group Policy for types of coverage available and eligible amounts of insurance

PLEASE COMPLETE IN FULL

IMPORTANT
Submit with completed Enrollment form.

EMPLOYER SECTION

Group #	Div. #	Employer/Group Name

Social Security #	Employee Name *(Last, First, Middle Initial)*

Telephone #	Address

PROPOSED INSURED(S)

Name	Relationship	Date of Birth	Height	Weight

REASON

NEW

- ☐ Late Applicant
- ☐ Applying for Coverage in Excess of the Guaranteed Amount
- ☐ Applying for Supplemental Coverage
- ☐ Other _____

CHANGE

- ☐ Increase in Coverage
- ☐ Adding Spouse
- ☐ Increasing Spouse
- ☐ Adding Dependent Child(ren)
- ☐ Other _____

APPLYING FOR . . .

YOU	LIFE	AD&D	VOLUNTARY LIFE	VOLUNTARY AD&D
Current Insurance				
Additional Insurance Requested				
Total New Coverage				

- ☐ Short Term Disability $ _____ *Weekly Benefit*
- ☐ Long Term Disability $ _____ *Monthly Benefit*
- ☐ Other $ _____

YOUR SPOUSE	LIFE	AD&D	VOLUNTARY LIFE	VOLUNTARY AD&D
Current Insurance				
Additional Insurance Requested				
Total New Coverage				

- ☐ Other $ _____

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 ROYALL STREET · CANTON, MASSACHUSETTS 02021 · 800-669-2668

Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY

(This authorization complies with the HIPAA Privacy Rule)

Name of *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

Name of Second *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *("Providers")* that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes.**

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization,** and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. **I understand that I have the right to revoke this authorization in writing,** at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient _____

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient _____

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____, the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured _____ Date _____

BOSTON MUTUAL PORTABILITY AND CONVERSION INFORMATION

Portability

If the insured is under age 60, he/she can "port" life insurance. That is, it can be continued as term life insurance until age 70. The ported coverage is guarantee issue if implemented within 31 days of retirement.

Portability enables the insured employee to continue all of their Group Term Basic Life Insurance* and/or Voluntary Life Insurance, including any Voluntary Life Insurance in effect on the spouse and children, upon leaving employment.

Portable Life Insurance is Group Term Life Insurance that does NOT include Waiver of Premium or Accidental Death and Dismemberment coverage.

If you are interested in purchasing Portable Life Insurance, please complete and return the attached notice to:

Group Billing Department
Boston Mutual Life Insurance Company
120 Royall Street
Canton, MA 02021-1098

Note: Because employees have only 31 days from the date employment ends, it is extremely important that the Employer provide them with this form on or before the date of termination. The portability feature is not available if the coverage terminated due to cancellation of the Group Policy.

Conversion

Conversion to permanent life is another continuation option to an insured regardless of his/her attained age at retirement. The conversion policy is guarantee issue if implemented within 31 days of retirement.

Use this form when an employee's group life insurance is reduced or cancelled due to age or termination of employment, including retirement.

Note: Because employees have only 31 days* from the date of reduction or termination to exercise the conversion privilege, it is extremely important that you provide them with this form on or before the date of reduction/termination.

The Employer/Plan Administrator (or an authorized representative) should complete the top portion of the form, including:
Name, Sex, Date of Birth and Address of the Employee
Amount of Insurance:
Terminations-not more than amount in force prior to termination of coverage
Reductions- not to exceed amount of coverage reduced by age
Insurance Termination or Reduction Date
Policy Number
Name of Group
Date of this Notice (date form is given to employee)
Employer Authorized Signature

The Employee should complete the remainder of the form.

Important Information About Portable Life Insurance

Portable Life Insurance is Group Term Life Insurance coverage under a group master policy. You may have the right to continue your Life Insurance by purchasing Portable Life Insurance because of the termination of your Basic Group Life and/or Voluntary Life Insurance.

YOU MUST APPLY FOR PORTABLE LIFE INSURANCE AND PAY THE APPLICABLE PREMIUM WITHIN 31 DAYS AFTER YOUR BASIC GROUP LIFE AND/OR VOLUNTARY LFE INSURANCE ENDED.

If you wish to apply for Portable Life Insurance, please complete and return this notice. This notice can also be faxed to us at 1-781-770-0490. The necessary information and forms will be mailed to you.

PLEASE PRINT

Name: _____

Address: _____

_____

Employer: _____

Group #: _____ Date your employment ended: _____

EPT - REQ *221-003 10/00*

_____

_____

_____

Group Billing Department
Boston Mutual Life Insurance Company
120 Royall Street
Canton MA 02021-1098