



**ENROLLMENT/REFUSAL REQUEST FORM**  
**THE PAUL REVERE LIFE INSURANCE COMPANY**  
 18 Chestnut Street, Worcester, MA 01608-1528

<b>FOR PAUL REVERE USE ONLY</b>	
DATE RECEIVED:	
MEMBER NUMBER	OCC CODE:
EFFECTIVE/RECORDED DATE:	

<input type="checkbox"/> NEW EMPLOYEE	<input type="checkbox"/> PREVIOUSLY INELIGIBLE EFF DATE _____ REASON: _____	<input type="checkbox"/> REINSTATED EMPLOYEE DATE REHIRED _____	<input type="checkbox"/> PART-TIME TO FULL TIME DATE REHIRED _____	<input type="checkbox"/> CHANGE OF STATUS		
GROUP NO.	ACCT.	CLASS	EMPLOYER NAME AND ADDRESS			
EMPLOYEE NAME: (LEAVE SPACE BETWEEN LAST MI FIRST)						
NO. OF HOURS WORKED PER WEEK	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE # CHILDREN _____	SOCIAL SECURITY NO.	DATE HIRED FULL TIME	DATE OF BIRTH	<input type="checkbox"/> UNION <input type="checkbox"/> NON-UNION
BASIC EARNINGS (Refer to your Plan Administrator for proper Earnings definition.) \$ _____ + \$ _____ = \$ _____ = \$ _____			<input type="checkbox"/> HOURLY <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY	<input type="checkbox"/> MONTHLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> ANNUALLY	<input type="checkbox"/> SALARIED <input type="checkbox"/> HOURLY <input type="checkbox"/> COMMISSIONED	<input type="checkbox"/> EXEMPT <input type="checkbox"/> NON-EXEMPT
BASE EARNINGS	COMMISSIONS (if applicable)	BONUS (if applicable)	TOTAL EARNINGS		OCCUPATION: (List Job Title & Major Responsibilities)	
					STATE YOU LIVE IN	ZIP CODE

**EMPLOYEE COVERAGE REQUESTED Select or refuse only the coverage(s) included in your Employer's policy or certificate**

	Request	Refuse		Request	Refuse
Long Term Disability (LTD) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Employee Supplemental AD&D .....	<input type="checkbox"/>	<input type="checkbox"/>
Core LTD + Buy-Up LTD .....	<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Dependent Life or Life/AD&D Spouse ..	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary LTD .....	<input type="checkbox"/>	<input type="checkbox"/>	Spouse Date of Birth: _____ (No AD&D) Child ..	<input type="checkbox"/>	<input type="checkbox"/>
Short Term Disability (STD) .....	<input type="checkbox"/>	<input type="checkbox"/>	Voluntary Life .....	<input type="checkbox"/>	<input type="checkbox"/>
Core STD + Buy-Up STD .....	<input type="checkbox"/>	<input type="checkbox"/>	Voluntary Dependent Life .....	<input type="checkbox"/>	<input type="checkbox"/>
Employee Basic Life and .....	<input type="checkbox"/>	<input type="checkbox"/>	Voluntary AD&D .....	<input type="checkbox"/>	<input type="checkbox"/>
Accidental Death & Dismemberment (AD&D) .....	<input type="checkbox"/>	<input type="checkbox"/>	Voluntary AD&D Family Plan .....	<input type="checkbox"/>	<input type="checkbox"/>
Employee Basic Life .....	<input type="checkbox"/>	<input type="checkbox"/>			
Basic Dependent Life .....	<input type="checkbox"/>	<input type="checkbox"/>			
Employee Supplemental Life .....	<input type="checkbox"/>	<input type="checkbox"/>			

**BENEFICIARY DESIGNATIONS**

<b>PRIMARY –</b>	FIRST	MI	LAST	RELATIONSHIP	DATE OF BIRTH
				<small>Equally or survivor(s), if any</small>	
BENEFICIARY ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) REQUIRED FOR FLORIDA AND VIRGINIA RESIDENTS					SOC. SEC. NO.
<b>SECONDARY –</b>	FIRST	MI	LAST	RELATIONSHIP	DATE OF BIRTH
				<small>Equally or survivor(s), if any</small>	
BENEFICIARY ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) REQUIRED FOR FLORIDA AND VIRGINIA RESIDENTS					SOC. SEC. NO.

**REQUEST FOR CHANGE**

<input type="checkbox"/> 1. PLEASE ADD DEPENDENT BENEFITS TO MY GROUP INSURANCE COVERAGE	DATE I ACQUIRED ELIGIBLE DEPENDENTS _____	
REASON: <input type="checkbox"/> MARRIAGE <input type="checkbox"/> BIRTH OF SON/DAUGHTER <input type="checkbox"/> OTHER (EXPLAIN): _____		
<input type="checkbox"/> 2. PLEASE CHANGE MY BENEFICIARY TO:	FIRST MI LAST RELATIONSHIP DATE OF BIRTH	
		<small>Equally or survivor(s), if any</small>
BENEFICIARY ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) REQUIRED FOR FLORIDA AND VIRGINIA RESIDENTS		SOC. SEC. NO. WITNESSED:
<input type="checkbox"/> 3. PLEASE CHANGE MY NAME	FROM: _____ TO: _____	

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION SHOWN ABOVE, INCLUDING THE REFUSAL SECTION, IS TRUE AND COMPLETE AND MY SIGNING BELOW INDICATES THAT I UNDERSTAND ALL INFORMATION GIVEN IS SUBJECT TO VERIFICATION. **I UNDERSTAND THAT COVERAGE UNDER THE GROUP POLICY WILL NOT GO INTO EFFECT UNLESS I AM ACTIVELY AT WORK ON OR AFTER THE PROPOSED EFFECTIVE DATE OF COVERAGE.**

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

SIGNATURE OF EMPLOYEE	DATE
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## ENROLLMENT REFUSAL REQUEST FORM

### TO THE EMPLOYEE

**Regardless of whether or not you contribute to the payment of the insurance, you are required to complete this Enrollment/Refusal Request Form. Be sure you indicate your acceptance or refusal for *each* benefit available to you under the group policy.**

Type or print clearly in ball point pen. Date, sign and return your form to your employer within 31 days of the date you become eligible for insurance. Group Insurance will become effective as described in the group policy. Employee insurance will not go into effect unless you are actively at work on the proposed effective date of coverage. Dependents insurance does not begin if the dependent is totally disabled or confined at home, in a hospital or elsewhere.

*Those benefits 100% paid by your Employer cannot be refused.*

*If you contribute to the cost of any benefit, you may refuse that benefit.* However, if you refuse coverage now and later request to add that coverage late entrant penalties will apply. For benefits, you will have to furnish, at your own expense, evidence of insurability satisfactory to The Paul Revere for each person applying late.

If you refuse coverage for yourself, you automatically refuse that coverage for any dependents.

*You must complete Form G-EVIAPP-NJ instead of this form G-2508-NJ if you are*

- applying for a contributory benefit more than 31 days after the date you became eligible for that benefit; or
- you are applying for a contributory benefit that you initially refused; or
- if evidence of insurability is a provision of the group policy

Your Group Insurance Administrator can provide you with Form G-EVIAPP-NJ for your completion.

**NOTE:** A person may not be insured under both Employee and Dependents Life insurance and/or Employee and Dependents Voluntary Accidental Death & Dismemberment Insurance. A dependent child may not be insured for Dependent Life and/or Voluntary AD&D as a dependent of more than one employee.

### BENEFICIARY DESIGNATION:

The beneficiary section should only be completed if the Group Policy includes Employee Life Insurance or Voluntary Accidental Death & Dismemberment Insurance. If more than one beneficiary is designated, settlement will be made in equal shares to each of the designated beneficiaries that survive you, unless you designate a specific percentage for each beneficiary.

The employee is automatically the beneficiary for benefits under the Dependent Life Insurance.

### TO THE EMPLOYER

1. Be sure to enter your group number and account number in the appropriate boxes.
2. Verify that the employee has completed, dated and signed his/her form.
3. Return the last copy to the employee for his/her records.
4. Retain the second copy for your records.
5. If any benefit is based on earnings, refer to your Group Policy for the definition of Earnings that applies.
6. Send the original copy of this form to The Paul Revere Life Insurance Company, Customer Account Services, P.O. Box 15123, Worcester, MA 01615-0123.

### TO THE EMPLOYEE AND THE EMPLOYER

**PLEASE READ THIS FORM. OMISSIONS OR MISSTATEMENTS MAY CAUSE AN OTHERWISE VALID CLAIM TO BE DENIED. INSURANCE WILL BE ISSUED ON THE BASIS THAT ALL THE INFORMATION SHOWN IS CORRECT AND TRUE.**