RIGHT TO CONVERT PROVISIONS

Conversion of Insured Employee's Group Life Insurance under this Policy

The Employee has the right to convert his or her group Life Insurance if all or a portion of it terminates for any reason unless it terminates because the Employee did not pay the required premium. The conversion is subject to the following rules:

1. The first premium must be sent with a written application for the conversion policy and must be received by Us within 31 days after the Employee's group Life Insurance terminates;
2. The premium due for the policy will be at Our usual rates. This rate will be based on the amount of insurance, class of risk, and the Employee's age on the date the conversion policy is issued;
3. The conversion policy may be any individual whole life policy We currently issue, except term insurance;
4. Evidence of insurability is not required; and
5. The conversion policy issued will be for an amount not to exceed what the Employee had before termination under this Policy and will not include waiver of premium or accidental death and dismemberment benefits.

If the Employee's insurance terminates due to termination of this Policy, an individual whole life policy can be issued. The Employee must have been insured for at least 5 years under this Policy. The same rules as shown above will apply, except that the amount of life insurance will be the lesser of:

1. The amount of life insurance under this Policy; less any amount of group life insurance the Employee receives or becomes eligible for within 31 days after this Policy terminates; or
2. $10,000.

If an Employee should die during the time in which he or she is entitled to apply for a conversion policy, We will pay the benefit that he or she had under this Policy. This will be done whether or not the Employee applied for the conversion policy. Any conversion policy issued with respect to this benefit will be put in force at the end of the 31 day period that application must be made.

Christopher Boudreau
Boudreau & Boudreau Insurance, Inc.
35 Lincoln Street
New Bedford, Ma. 02740

(508) 999-4924 ph
(508) 999-4934 fax

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 ROYALL STREET • CANTON, MASSACHUSETTS 02021

• NOTICE OF CONVERSION PRIVILEGE FOR GROUP LIFE INSURANCE •

THIS PORTION MUST BE COMPLETED AND SIGNED BY THE EMPLOYER:

Name of Insured	Social Security #	M or F	Amount of Insurance Eligible to Convert	Date of Birth

Address	Insurance Termination or Reduction Date

Policy Number	Name of Group	Last Day of Full Time Employment
G -		

Date of this Notice *Employer Authorized Signature* *Telephone #*

THIS PORTION MUST BE COMPLETED AND SIGNED BY THE EMPLOYEE:

SUPPLEMENTARY STATEMENT TO BE ATTACHED TO AND MADE PART OF THE APPLICATION FOR LIFE INSURANCE

The following statement is made as an inducement to the Boston Mutual Life Insurance Company to issue a life insurance contract without a tobacco user's surcharge.

Have you used any form of tobacco products *(cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches)* within the past 36 months?

YES ☐ NO ☐

Date *Signature of Proposed Insured*

Your group life insurance has been terminated or reduced as of the Insurance Termination or Reduction Date indicated. However, you can convert to an individual life insurance policy in accordance with the terms of the group policy's Conversion Privilege, summarized in your Certificate. The individual policy will be issued without medical examination based upon the rate applicable to the class of risk to which you belong and to your present attained age.

Please forward the white copy of this completed form to the Group Conversion Department. Boston Mutual Life Insurance Company, 120 Royall Street, Canton, MA 02021. Upon receipt of this form we will forward to you an application with premium rates and instructions. The return of this notice does not bind you in any way to complete an application.

If you choose to apply for an individual life insurance policy, your application must be completed and sent to Boston Mutual Life Insurance Company with the full first premium within 31 days after your group life insurance terminated. If this Notice of Conversion Privilege is given to you more than 15 days after the Termination Date shown above, the conversion period will be extended for a maximum of 15 days from the date you received this notice. However, in all cases the Right to Convert ends on the 91st day after the Termination Date.

NOTE: This Notice of Conversion application applies to the following states: AL; AK; AZ; DE; DC; FL; HI; ID; IL; KS; ME; MD; MA; MO; MT; NE; NV; NJ; NM; OH; OK; PA; SD; TN; VT; WV; WY

Contact : Christopher Boudreau (508) 999-4924 email: bbinsinc@comcast.net

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 _____