

Enrollment Form Group Policy No. 877075

1. Employee Information

Name	(first middle last)		Eagle ID
	(print) _____		_____ - _____
Home Address		Telephone Numbers	Date of Hire Date of Birth
_____		Campus Ext. _____	_____ _____
_____		Home# () _____ - _____	Male ____ Female ____

2. Request for Dependent Life Insurance [IMPORTANT – First Read Instructions on Reverse]

Circle the Units of Dependent Insurance you currently have: None 1 2 3

Select the TOTAL number of Units you now wish to have:

(For Benefits Use)
Effective Date

Either _____ 1 Unit (Spouse \$10,000; Each Child \$5,000)	1. _____
Or _____ 2 Units (Spouse \$20,000; Each Child \$10,000)	2. _____
Or _____ 3 Units (Spouse \$30,000; Each Child \$15,000)	3. _____

3. Eligible Dependents to be Insured

Name (first middle last)	Date of Birth	Relationship
Spouse _____	_____	_____
Child _____	_____	_____
Child _____	_____	_____
Child _____	_____	_____
Child _____	_____	_____

4. Certification and Authorization

I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all the terms of the Plan of Insurance contained in the group policy and summarized in the announcement material provided to me and the certificate issued to me.

I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. I understand that, if I fail to sign this form within 60 days of my date of eligibility, my and my dependents' eligibility may be affected.

I request my employer to arrange for the issuance of Group Life Coverage for which I am or may become eligible, and I authorize deductions of the required contributions from my earnings. This authorization applies to the Plan until rescinded by me in writing.

[Misrepresentation: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or, for the purpose of misleading, conceals information concerning any fact material thereto, commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.]

Employee Signature _____ Date _____

Boston College Authorization _____ Date _____