ENROLLMENT/REFUSAL REQUEST FORM

THE PAUL REVERE LIFE INSURANCE COMPANY
2211 Congress Street, Portland, ME 04122

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

☐ NEW EMPLOYEE	☐ PREVIOUSLY INELIGIBLE EFF DATE _____ REASON:	☐ REINSTATED EMPLOYEE DATE REHIRED _____	☐ PART-TIME TO FULL TIME DATE REHIRED _____	☐ 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	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE # CHILDREN____	SOCIAL SECURITY NO.	DATE HIRED FULL TIME	DATE OF BIRTH	☐ UNION ☐ NON-UNION

BASIC EARNINGS (Refer to your Plan Administrator for proper Earnings definition.)
$_____ + $_____ = $_____ = $_____
BASE EARNINGS | COMMISSIONS (if applicable) | BONUS (if applicable) | TOTAL EARNINGS

☐ HOURLY ☐ MONTHLY
☐ WEEKLY ☐ SEMI-MONTHLY
☐ BI-WEEKLY ☐ ANNUALLY

☐ SALARIED ☐ EXEMPT
☐ HOURLY ☐ NON-EXEMPT
☐ COMMISSIONED

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
Long Term Disability (LTD)	☒	☐
Core LTD + Buy-Up LTD	☐	☐
Voluntary LTD	☐	☐
Short Term Disability (STD)	☐	☐
Core STD + Buy-Up STD	☐	☐
Employee Basic Life and	☒	☐
Accidental Death & Dismemberment (AD&D)	☒	☐
Employee Basic Life	☐	☐
Basic Dependent Life	☐	☐
Employee Supplemental Life	☐ $_____	☐

	Request	Refuse
Employee Supplemental AD&D	☐ $_____	☐
Supplemental Dependent Life or Life/AD&D Spouse	☐ $_____	☐
Spouse Date of Birth: _____ (No AD&D) Child	☐ $_____	☐
Voluntary Life	☐ $_____	☐
Voluntary Dependent Life	☐	☐
Voluntary AD&D	☐ $_____	☐
Voluntary AD&D Family Plan	☐	☐

BENEFICIARY DESIGNATIONS

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

REQUEST FOR CHANGE

☐ 1. PLEASE ADD DEPENDENT BENEFITS TO MY GROUP INSURANCE COVERAGE DATE I ACQUIRED ELIGIBLE DEPENDENTS _____
REASON: ☐ MARRIAGE ☐ BIRTH OF SON/DAUGHTER ☐ OTHER (EXPLAIN):

☐ 2. PLEASE CHANGE MY BENEFICIARY TO: FIRST MI LAST Equally or survivor(s), if any	RELATIONSHIP	DATE OF BIRTH
BENEFICIARY ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) REQUIRED FOR FLORIDA AND VIRGINIA RESIDENTS	SOC. SEC. NO.	WITNESSED:

☐ 3. PLEASE CHANGE MY NAME
FROM: TO:

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION SHOWN ABOVE, INCLUDING THE REFUSAL SECTION, IS CORRECT 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 THE 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