BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x700**

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

Group Number-Division Number | Sapulpa Public Schools — 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 | Rate Basis

Spouse *(Last, First, Middle)* | Gender *(M/F)* | Date of Birth | Age | No. of Dependents

LIFE - DISABILITY

ONLY ELECT BOSTON MUTUAL COVERAGES MADE AVAILABLE TO YOU THROUGH YOUR EMPLOYER.

BASIC	YES	NO	Insurance Amount
LIFE	☐	☐	$
AD&D	☐	☐	$
DEPENDENT LIFE:			
SPOUSE	☐	☐	$
CHILD(REN)	☐	☐	$
SHORT TERM DISABILITY	☐	☐	$
LONG TERM DISABILITY	☐	☐	$
❑ OTHER *(Please specify coverage & amt.)*			

VOLUNTARY	YES	NO	Insurance Amount
LIFE	☐	☐	$
AD&D	☐	☐	$
DEPENDENT LIFE:			
SPOUSE LIFE AND AD&D	☐	☐	$
CHILD(REN)	☐	☐	$
SHORT TERM DISABILITY	☐	☐	$
LONG TERM DISABILITY	☐	☐	$
❑ OTHER *(Please specify coverage & amt.)*			

BENEFICIARY

BENEFICIARY(IES) FOR LIFE AND/OR AD&D BENEFITS: ***(Attach Additional Beneficiaries on a signed and dated 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.

Please complete as much beneficiary information as you can provide.

SIGNATURE

REFUSAL OF INSURANCE

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:

❑ All Coverages ❑ Life & AD&D ❑ Dependent Coverage ❑ Short Term Disability ❑ Long Term Disability

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage(s) 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 _____

EMPLOYEE SIGNATURE REQUIRED

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 _____

OKLAHOMA TEACHERS' RETIREMENT SYSTEM
P.O BOX 53524 - OKLAHOMA CITY, OK 73152
405-521-2387 OR TOLL FREE 1-877-738-6365
Fax: (405) 522-2521 - www.ok.gov/trs

CHANGE OF NAME/ADDRESS NOTIFICATION

☐ Inactive ☐ Retired

_____ SSN# or Ret#

_____ Current Telephone Number

NAME CHANGE

Date Effective_____

Previous Name Acct: _____ First Name _____ Middle Initial _____ Last Name

New Name on Acct: _____ First Name _____ Middle Initial _____ Last Name

Reason for Name Change:_____

All requests for change of name must include legal documentation (i.e. Marriage Certification, Divorce Decree…)

ADDRESS CHANGE

Date Effective _____

_____ First Name _____ Middle Initial _____ Last Name

Previous Address:

_____ Address _____ City _____ State _____ Zip

New Address:

_____ Address _____ City _____ State _____ Zip

Note:
OTRS cannot use Post Office forwarding stickers as authorization for any change of address. Requests for a change of address or change of name must be signed by the client in order to make the change to your permanent record.

If this request is signed by a LEGAL GUARDIAN or POWER OF ATTORNEY, documentation for this authority must be included with this form and will be retained in the client's permanent file. Without this documentation address or name change cannot be made.

Are you currently scheduled/applying for a withdrawal of funds:

_____ Signature

_____ Date

OKLAHOMA
Office of Management
& Enterprise Services

Employees Group Insurance Division
P.O. Box 11137, Oklahoma City, OK 73136-9998
405-717-8780 or toll-free 800-752-9475
TDD: 405-949-2281 or toll-free 866-447-0436
FAX: 405-717-8939

Change of Address

Member Name: _____

SSN or Member ID #: _____

Member Phone Number: _____

Alternate Phone Number: _____

Email Address: _____

New Address: _____

_____

Member's Signature: _____

Date: _____

Current Employees – Return this form to your insurance coordinator.

Former Employees – Return this form to EGID at the address or FAX number listed above.

Revised 9/21/2021