OPEN ENROLLMENT – APRIL 1-30, 2025

Insurance that Fits Your Life

We're excited to share an insurance option available to you through your employer. We've made it simple to understand how it helps protect you and your family.

Basic Life Insurance

Life insurance that's there when you need it

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) –

This life insurance option provides your beneficiaries with money that can help keep your family financially secure when you pass away. This can help your loved ones pay bills, funeral and daily expenses, or mortgage payments.

If you suffer a serious injury or pass away due to an accident this coverage provides additional money that can help cover expenses and other things your loved ones may need.

How it Works

- It's easy to set up financial protection for you, your family and your future. And it'll be there when you need it.
- The cost for insurance is split between you and your employer, so you don't have to pay the full amount. It will be automatically taken from your paycheck – set it and forget it!
- All full-time active employees working a minimum of 20 hours per week are eligible.
- During this special open enrollment, no medical questions are required to sign up for Basic Life Insurance.
- An additional optional life insurance product is also available. This is fully paid for by the employee and medical questions are required to enroll.
- When you retire, your life insurance coverage will reduce to $5,000. Your AD&D benefit will go away once you retire.

Ready to Get Started? Contact your HR Team for more details

HR@sudbury.ma.us | 978.639.3348

BOSTON MUTUAL LIFE INSURANCE COMPANY –1891–

120 Royall Street, Canton, MA 02021 | www.bostonmutual.com | 800.669.2668

BOSTON MUTUAL LIFE INSURANCE COMPANY – 1891–

FAMILY MATTERS. NO MATTER WHAT.®

Basic Life and Accidental Death & Dismemberment (AD&D) Benefit Summary

Designed for the Employees of

Town of Sudbury, MA

ELIGIBILITY & BENEFIT FEATURES

Class 1: All Full-Time Active Employees working a minimum of 20 hours per week.

Basic Life and AD&D: **$15,000**

COST OF COVERAGE

The premium for your coverage is paid by you and your employer.

GUARANTEED ISSUE

No medical questions are required for amounts up to **$15,000** for first time applicants in their initial eligibility period.

REDUCTIONS IN BENEFITS

Your Life benefit amount will reduce upon retirement to **$5,000** .

Your AD&D benefit will terminate upon retirement.

* *All insurance benefits shall terminate upon the employee's termination of employment.*

ADDITIONAL FEATURES

Accelerated Death Benefit: This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary. To be eligible, the employee must have at least $10,000 in basic life coverage.

Accidental Death & Dismemberment: Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions. An additional death benefit is paid if death is the result of a covered accident.

Portability: If you leave your employer prior to age **60** , the coverage is portable for you, your spouse under age **60** and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or AD&D.

Conversion: Employees have 31 days from the date of termination to convert their basic life insurance to an individual permanent life insurance policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium or AD&D.

Waiver of Premium: If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Boston Mutual will continue your insurance without any further payment of premiums subject to the provisions of the contract.

Also Included: Education Benefit, Seat Belt Benefit, and Repatriation of Remains Benefit.

EXCLUSIONS

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: self-inflicted injuries; suicide or attempted suicide; riot or war; diseases; ptomaine or bacterial infection; drug and/or alcohol abuse; commission of an assault or felony by an employee; accident while serving on active duty; travel or flight in any aircraft or device which can fly above the earth's surface *(does not apply to commercial flights);* or injury which occurred before the employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefit administrator.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

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

Town of Sudbury, MA
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

7/1/2025

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 # 1375 **Div.** 1

	YES	NO	Insurance Amount
LIFE & AD&D	❑	❑	$ 15,000

You Must Have Voluntary Coverage to Elect Dependent Coverage

VOLUNTARY:
Group # 3125 **Div.** 1

	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 _____

TOWN OF SUDBURY

OPTIONAL LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT *G-3125*

100% Employee paid ***Employee must be enrolled in the $15,000 Basic to join this plan***

Active employees may elect insurance amounts equal to 1 x annual salary, minus $1,000. Amounts can be elected from $1,000 to a maximum of $74,000 based on the guidelines of the Chapter 32B section 11A chart attached.

Upon retirement, full benefit continues until age 75 at which time, all benefits terminate and conversion is available.

Employees have two options to choose from when selecting Optional insurance:

Automatic Maximum Allowable **- The maximum amount of insurance allowable based on the employee's salary. (The Town must inform Boston Mutual of annual salary changes.) This insurance would automatically increase when salary adjustment change to the next higher salary band. Under the Automatic increase, insurance amounts from $1,000 to $40,000 are guarantee issue. Amounts over the guarantee issue amount require evidence of insurability.**

Flat amount of insurance **– If the employee desires a flat amount, he/she may elect the maximum amount they are eligible for based on his/her salary, or the employee may choose any amount less than the maximum amount eligible for. This is a flat amount of insurance, which does not change with a salary increase. Amounts over $40,000 require evidence of insurability forms. Any increase in insurance outside of an open enrollment, would require evidence of insurability forms.**

Optional Life and AD&D rates are based on age, premium amounts change each time the insured's age goes into the next higher age bracket.

Age	Monthly Life and AD&D Rate per 1000
Under age 40	$ .20 per 1000
40-44	.25 per 1000
45-49	.40 per 1000
50-54	.70 per 1000
55-59	1.25 per 1000
60-64	1.45 per 1000
65- Retirement	2.00 per 1000
Retirees to age 75	4.75 per 1000

Guarantee Issue Limit is $40,000 if elected within 31 days from date of hire
Amounts elected beyond eligibility and amounts over $40,000 for new hires require Evidence of Insurability.

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 ROYALL STREET · CANTON, MASSACHUSETTS 02021 · 800-669-2668

Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY

(This authorization complies with the HIPAA Privacy Rule)

Name of *(Proposed)* Insured/Patient *(please print)* — Date of Birth ___/___/___

Name of Second *(Proposed)* Insured/Patient *(please print)* — Date of Birth ___/___/___

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *("Providers")* that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes.**

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization,** and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. **I understand that I have the right to revoke this authorization in writing,** at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative — Date

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative — Date

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____ , the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured — Date

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 Royall Street • Canton, MA 02021 1-800-669-2668 Ext. 473

STATEMENT OF INSURABILITY FORM FOR GROUP INSURANCE

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

Refer to the Group Policy for types of coverage available and eligible amounts of insurance.

PLEASE COMPLETE IN FULL

IMPORTANT
Submit with completed Enrollment form.

EMPLOYEE/EMPLOYER

Group #	Div. #	Employer/Group Name
Social Security #		Employee Name *(Last, First, Middle Initial)*
Telephone #		Address

PROPOSED INSURED(S)

Name	Relationship	Date of Birth	Height	Weight *(if pregnant, pre-pregnancy weight)*

REASON

NEW

- ❑ Late Applicant
- ❑ Applying for Coverage in Excess of the Guaranteed Amount
- ❑ Applying for Supplemental Coverage
- ❑ Other _____

CHANGE

- ❑ Increase in Coverage
- ❑ Adding Spouse
- ❑ Increasing Spouse
- ❑ Adding Dependent Child(ren)
- ❑ Other _____

INSURANCE

YOU	**LIFE**	**AD&D**	**VOLUNTARY LIFE**	**VOLUNTARY AD&D**
Current Insurance				
Additional Insurance Requested				
Total New Coverage				

- ❑ Short Term Disability $ _____ *Weekly Benefit*
- ❑ Long Term Disability $ _____ *Monthly Benefit*
- ❑ Other $ _____

YOUR SPOUSE	**LIFE**	**AD&D**	**VOLUNTARY LIFE**	**VOLUNTARY AD&D**
Current Insurance				
Additional Insurance Requested				
Total New Coverage				

- ❑ Other $ _____

EVIDENCE OF INSURABILITY

Existing Coverage	Please list all life insurance and/or annuity contacts now in-force or pending on your life				
	Name of Company *(if replacement include Policy No.)*	Life Amount	AD&D Amount	Year Issued or Pending	Do you intend to replace or change this coverage if you and your dependents are approved for the insurance applied for on this application?
					❑ YES ❑ NO
					❑ YES ❑ NO

To be Completed for ALL Proposed Insured(s) if Required by the Group Insurance Contract

1. Have you used any form of tobacco products *(cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches)* within the past 12 months? ** **Employee** ❑ YES ❑ NO **Spouse** ❑ YES ❑ NO

** ***I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted only for misstatement of age or sex.***

2. In the past 5 years, have ANY of the proposed insureds been diagnosed, treated, tested positive for or been given medical advice by a licensed medical professional that they had: A) sleep apnea, asthma or emphysema; B) high blood pressure, stroke chest pain, transient ischemic attack (TIA), heart or circulatory disease or disorder; C) intestinal disease or disorder or ulcer; D) diabetes; E) leukemia, cancer, tumor or malignancy; F) epilepsy, mental or nervous disease or disorder; G) kidney or genito-urinary disease or disorder; H) disorder of the back, muscles, bones or joints; I) liver disease or disorder; J) pancreatitis (new or acute); or K) thyroid disorder? ❑ YES ❑ NO
3. In the past 5 years, have ANY of the proposed insureds been treated for or been diagnosed by a licensed medical professional as having an immune deficiency disorder or AIDS (Acquired Immune Deficiency Syndrome)? ❑ YES ❑ NO
4. In the past 5 years, have ANY of the proposed insureds; 1) been hospitalized or had hospitalization recommended; 2) had a physical examination or medical test with other than normal results? ❑ YES ❑ NO
5. Within the next 2 years, do you or your spouse: A) fly, or intend to fly, as pilot or crew member; B) race or test drive any form of vehicle; C) scubadive; D) hang glide or sky dive? ❑ YES ❑ NO
6. Have ANY of the proposed insured, within the past 5 years, used or are they currently using or received treatment or consultation for the use of heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs or alcoholism? ❑ YES ❑ NO
7. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having memory loss? ❑ YES ❑ NO
8. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Amytrophic Lateral Sclerosis (ALS)? ❑ YES ❑ NO
9. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having autism? ❑ YES ❑ NO
10. In the past 2 years, have any of the proposed insureds been treated, examined or advised by a licensed medical professional for attempted suicide? ❑ YES ❑ NO
11. In the past 5 years, have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Huntington's Chorea? ❑ YES ❑ NO

To be Completed if Applying for Disability Insurance

12. Are ANY of the proposed insureds currently pregnant? ❑ YES ❑ NO

Details for questions 2-12 answered "YES". Include question number. *(Attach additional details on a signed and dated separate sheet)*

Name	Medical Condition	Date(s)	Details/Treatment	Name & Address of Attending Physicians and Hospitals

AUTHORIZATION TO OBTAIN INFORMATION

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. *(formally known as Medical Information Bureau, Inc.)*, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

MIB REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

CONSUMER REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report, which may include a report from MIB, Inc. *(formerly Medical Information Bureau, Inc.)* on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

REPRESENTATIONS AND NOTICE TO APPLICANTS

I/we have read the Statement of Insurability form and represent that the statements and answers are complete and true to the best of my/our knowledge and belief. I/we agree that this form shall form the basis for and become a part of the consideration for the insurance applied for.

CAUTION: Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Proposed Insured *(Employee/Member)*	Date	Signed & Dated at *(City, State)*
Signature of Proposed Insured *(Other than Employee/Member) (Employee/Member if the proposed insured is under 15)*	Date	Signed & Dated at *(City, State)*

MUST BE USED WITH HIPAA FORM DESIGNATED FOR YOUR STATE