Questions?
Please Contact Us At
Group Billing Department-G
P.O. Box 55154
Boston, Massachusetts 02205-5154
Phone: 1-800-669-2668, Ext. 700
Fax: 1-781-770-0575
Email: GroupAdmin@BostonMutual.com

GROUP INSURANCE
REQUEST FOR CHANGE

SEE REVERSE SIDE FOR DETAILED INSTRUCTIONS

EMPLOYER (POLICYHOLDER) NAME:	GROUP POLICY #	DIVISION #	DEPT. I.D.	PREPARED BY (SIGNATURE/TITLE):	DATE
	G-				

REQUIRED INFORMATION				INDICATE CHANGES ONLY							COMPLETE FOR FAMILY PLAN CHANGES ONLY ***			
							SALARY							
SOCIAL SECURITY # OR CERTIFICATE #	EMPLOYEE'S NAME (LAST, FIRST, MI)	EFFECTIVE DATE OF CHANGE	TXN *	CLASS	UNITS	OCCUPATION	SALARY TYPE **	AMOUNT	DIV # AND/OR DEPT. I.D.		SPOUSE'S NAME (LAST, FIRST, MI)	SPOUSE DATE OF BIRTH		NO. OF DEP.

***TXN CODES:** **T** = Termination of Coverage. **R** = Reinstatement of Coverage (indicate any changes from original coverage and the reason for the reinstatement).
N = Name Change (list new name and put former name in parenthesis after it.) **C** = Change in Coverage: For *Class Change*, list new class and information used to determine class; *For Occupation Change,* list new occupation; For *Salary change*, list new salary and type. *See reverse for Dependent Life and Major Medical TXN Codes.*

** **SALARY TYPE CODES:** **W =** Weekly **M** = Monthly **A** = Annual **S** = Semimonthly **B**=Biweekly **H** = Hourly

*** See reverse side of this page for complete instructions on changes in Spouse and Dependent coverage.