City of Boston
Non-Medicare Health Insurance Enrollment Form

Employee ID: _____

Return completed form to
Health Benefits & Insurance Division
Boston City Hall, Room 807
Boston, MA 02201
email: hbi@boston.gov

Part 1 Identifying Information

1. Name (Last, First, Middle Initial)	2. Sex (M/F)	3. Date of Birth (mm/dd/yyyy)	4. SSN

5. Home Address (Including Zip Code)	6. Check one:	7. Home Phone 8. Work Phone
	☐ Active Employee ☐ Retiree ☐ Surviving Spouse ☐ COBRA	

Part 2 Health Coverage

1. Check one:	2. Select one of the health plans below	4. Select coverage level
☐ New Enrollment **(Basic Life Insurance Form Mandatory)** ☐ Change Enrollment (Add/Remove Dep) ☐ Decline/Waive Coverage ☐ Terminate/Cancel Existing Coverage ☐ Annual Enrollment	☐ BCBS HMO (Network Blue New England) ☐ BCBS PPO (Blue Care Elect Preferred) ☐ Mass General Brigham Health Value HMO Please see the comparison chart for the monthly premiums	☐ Individual ☐ Family
	3. PCP (Primary Care Physician)	5. Effective Date

Part 3 Spouse/Dependent Information (to be completed if enrolling in Family Coverage)

List below all family members, including your spouse or former spouse (if eligible), who will be covered under your health plan. Attach a separate sheet if additional space is required. Please provide all Social Security Numbers (required under Federal Law Section 111) and exact dates of birth for each dependent. Important: The City of Boston requires you to provide a copy of eligibility documents such as a marriage certificate, legal separation agreement, divorce decree, birth certificate, certificate of appointment as legal guardian, etc., for each covered spouse/dependent.

Add/Remove + / -	Last Name	First Name	Relationship	Date of Birth (mm/dd/yyyy)	Sex (M/F)	SSN (required)	PCP

Spouse Information Only complete if covering a spouse

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare Claim Number: _____

Former Spouse Information Only complete if covering a former spouse

Date of Divorce: _____

Former Spouse Home Address: _____

City: _____ State: _____ Zip: _____

Is your former spouse remarried? ☐ Yes ☐ No If yes, date of remarriage: _____

Are you remarried? ☐ Yes ☐ No If yes, date of remarriage: _____

Is your former spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare Claim Number: _____

Part 4 Signature Required

Deduction Authorization: I authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected.
Health Insurance: I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan.
Survivors: I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for City of Boston coverage.

Retirees must collect a pension from Boston retirement system to be eligible for City of Boston coverage.

_____ _____

Signature of Applicant Date Signature of Authorized Official Date

City of Boston
Basic Life Insurance Enrollment Form
Policy Number – 25373

Employee ID: _____

Return completed form to
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Boston City Hall, Room 807
Boston, MA 02201
email: hbi@boston.gov

Eligibility: Employees working a minimum of 20 hours per week. The City of Boston requires eligible employees to enroll in Basic Life coverage in order to enroll in health insurance coverage. See Basic Life coverage levels below.

Class 1 Active and retired employees $5,000

Class 2 Eligible Union Active Employees $5,000 or $10,000 (AFSCME (City Wide), Boston Typographical Union Local 13, Boston Newspaper Printing Pressman's Association, IBEW Local 103, Graphic Arts, Local 600, National Conference of Firemen & Oilers, OPEIU, SENA Local 9158, AFSCME Local 1526)

Class 2 Reduces to $5,000 at retirement or employee no longer eligible for class

Part 1 – Identifying Information

1. Name (Last, First, Middle Initial)	2. Sex (M/F)	3. Date of Birth (mm/dd/yyyy)	4. SSN

5. Home Address (Including Zip Code)	6. Check one: ☐ Active Employee ☐ Retiree	7. Home Phone 8. Work Phone

Part 2 – Basic Life Insurance

1. Check one:	2. Select one of the coverage levels below	3. Effective Date
☐ New Enrollment ☐ Change/Update Beneficiary ☐ Cancel Policy	☐ $5,000 (Active & Retired Employees) ☐ $10,000 (Only available for certain Unions)	

Part 3 – Beneficiary Information

Primary Beneficiary: Designate at least one primary beneficiary for your policy. It is important to provide the correct home address and phone number**. 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. Attach a separate sheet if additional space is required.

Last Name	First	Relationship	Date of Birth (mm/dd/yyyy)	Home Address (Street, City, State, Zip)	Phone Number	% of Benefit

Contingent Beneficiary: Designate the contingent beneficiary who will receive the benefits if the primary beneficiary has died at the time the benefit is to be paid. It is important to include the correct home address and phone number.

Last Name	First	Relationship	Date of Birth (mm/dd/yyyy)	Home Address (Street, City, State, Zip)	Phone Number

Part 4 – 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.

Deduction Authorization: I authorize the City of Boston, or the Boston Retirement Board, to deduct from my payroll or pension check the amount required for the coverage I have selected.

Retirees must collect a pension from Boston retirement system to be eligible for City of Boston coverage.

Signature of Applicant _____ Date _____

Signature of Authorized Official _____ Date _____