

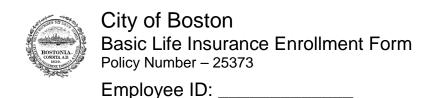
## City of Boston Non-Medicare Health Insurance Enrollment Form

Employee ID: \_\_\_\_\_

Return completed form to **Health Benefits & Insurance Division Boston City Hall, Room 807 Boston, MA 02201** 

Fax: 617-635-3932

| Part 1 Ide  | entifying Information     |  |  |                                       |                                |              |                  |   |  |  |  |  |  |
|---|---------------------------|--|--|---------------------------------------|--------------------------------|--------------|------------------|---|--|--|--|--|--|
|   |                           |  |  | x (M/F) 3. Date of Birth (mm/dd/yyyy) |                                |              | 4. SSN           | 4. SSN  |  |  |  |  |  |
| 5. Home A   |                           | 6. Check one:  Active Employee  Retiree  Surviving Spouse  COBRA |  |                                       | 7. Home Phone<br>8. Work Phone |              |                  |   |  |  |  |  |  |
| Part 2 Health Coverage  |                           |  |  |                                       |                                |              |                  |   |  |  |  |  |  |
| 1. Check one:  New Enrollment (Basic Life Insurance Form Mandatory)  Change Enrollment (Add/Remove Dep)  Decline/Waive Coverage  Terminate/Cancel Existing Coverage  Annual Enrollment  |                           |  | 2. Select one of the health plans below  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  3. PCP (Primary Care Physician) |                                       |                                |              |                  | 4. Select coverage level  Individual  Family  5. Effective Date |  |  |  |  |  |
| Dart 2 Sn   | ouse/Dependent Info       | rmation (to l  | ha complet   | tod if opro                           | lling in Family                | Coverage     |                  |   |  |  |  |  |  |
| 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<br>+ / -   | Last Name Fire            |  | me Re  | lationship                            | Date of Birth<br>(mm/dd/yyyy)  | Sex<br>(M/F) | SSN (required)   | PCP   |  |  |  |  |  |
|   |                           |  |  |                                       |                                |              |                  |   |  |  |  |  |  |
|   |                           |  |  |                                       |                                |              |                  |   |  |  |  |  |  |
|   |                           |  |  |                                       |                                |              |                  |   |  |  |  |  |  |
|   |                           |  |  |                                       |                                |              |                  |   |  |  |  |  |  |
|   |                           |  |  |                                       |                                |              |                  |   |  |  |  |  |  |
| Spouse Info   | <u> </u>                  |  |  | licere Cleim                          | Number                         |              |                  |   |  |  |  |  |  |
| _   | se enrolled in Medicare?  |  |  |                                       | Number:                        |              |                  |   |  |  |  |  |  |
| Date of Divorce: Former Spouse Home Address: City: State: Zip: Is your former spouse remarried?   |                           |  |  |                                       |                                |              |                  |   |  |  |  |  |  |
| Part 4 Sig  | gnature Required          |  |  |                                       |                                |              |                  |   |  |  |  |  |  |
| required for the Health Insur hospital leave Survivors: I a Boston cover  | am a surviving spouse and | ed.<br>ace I choose a h  | nealth plan, I d   | cannot chan                           | ge plans until the r           | next annual  | enrollment, even | if my doctor or   |  |  |  |  |  |
| Signature of A  | Applicant                 |  | Date   | S                                     | ignature of Authori            | zed Official |                  | Date  |  |  |  |  |  |



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**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, I  |                  | 2.             | Sex (M/F)                    | 3. Date of Birth (mm/dd/yyyy)  | 4. SSN                         |                 |  |  |  |  |  |  |  |
| 5. Home Address (Inc.  | luding Zip Code) | ·              |                              | 6. Check one:  Active Employee  Retiree                              | 7. Home Phone<br>8. Work Phone |                 |  |  |  |  |  |  |  |
| Part 2 – Basic Life Insurance  |                  |                |                              |  |                                |                 |  |  |  |  |  |  |  |
| 1. Check one:  New Enrollment Change/Update Ben Cancel Policy  | eficiary         | <b>\$5,000</b> | O (Active & Re               | overage levels below<br>tired Employees)<br>ible for certain Unions) | 3. Effective Date              |                 |  |  |  |  |  |  |  |
| Part 3 – Beneficiary   | Information      |                |                              |  |                                |                 |  |  |  |  |  |  |  |
| <b>Primary Beneficiary:</b> 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 Birtl<br>(mm/dd/yyy) | Tromo Address (Street, Sity  |                                | Phone<br>Number |  |  |  |  |  |  |  |
|  |                  |                |                              |  |                                |                 |  |  |  |  |  |  |  |
| 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 R   |                  |                |                              |  |                                |                 |  |  |  |  |  |  |  |
| 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            |  |  |  |  |  |  |  |