# 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 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<br>8. Work Phone |
|---|---|---|
| | ☐ Active Employee<br>☐ Retiree<br>☐ Surviving Spouse<br>☐ 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)**<br>☐ Change Enrollment (Add/Remove Dep)<br>☐ Decline/Waive Coverage<br>☐ Terminate/Cancel Existing Coverage<br>☐ Annual Enrollment | ☐ AllWays Health Partners (HMO)<br>☐ Harvard Pilgrim Health Care (HMO)<br>☐ Blue Cross Blue Shield Blue Care Elect (PPO) | ☐ Individual<br>☐ 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 |
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### 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