City of Boston

MetLife Retiree Dental Enrollment Form - 241196

Employee ID: ______________

Return completed form to
Boston City Hall, Room 807
Boston, MA 02201
Phone: 617-635-4570 | Fax: 617-635-3932
Email: hbi@boston.gov

Part 1 – Identifying Information

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

5. Primary Phone	6. Primary Email

7. Home Address (Street, City, State, Zip Code)	8. Check one status:
	☐ Retiree ☐ Surviving Spouse

Part 2 – Retiree Dental Coverage

1. Check one event:	2. Select coverage level *(monthly rate)*	3. Effective Date
☐ New Enrollment ☐ Change Enrollment (Add/Remove Dep) ☐ Terminate/Cancel Existing Coverage ☐ Annual Enrollment *(Effective 07/01/22)*	☐ Retiree Only *($38.99)* ☐ Retiree + 1 *($74.02)* ☐ Retiree + Family *($122.38)*	

Part 3 – Spouse/Dependent Information (to be completed if enrolling with Dependent Coverage)

List below all family members, including your spouse or former spouse (if eligible), who will be covered under your dental 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 a 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)

Part 4 – Signature Required

Other Coverage: I acknowledge that if I retired as uniform police or firefighter or from the Boston Public Schools (non-managerial), the retiree chapter of my union may provide me with dental coverage.

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

Deduction Authorization: I direct my pension authority to deduct from my pension check the amount required for the selected coverage.

Survivors: I am a surviving spouse and certify that I have not remarried and understand that I am no longer eligible for City of Boston coverage if I do remarry. If I do not receive a survivor's pension, I will be mailed monthly billing statements.

Signature of Applicant	Date	Signature of Authorized Official	Date