



# 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: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> COBRA	7. Home Phone  8. Work Phone

## Part 2 Health Coverage

1. Check one: <input type="checkbox"/> New Enrollment ( <b>Basic Life Insurance Form Mandatory</b> ) <input type="checkbox"/> Change Enrollment (Add/Remove Dep) <input type="checkbox"/> Decline/Waive Coverage <input type="checkbox"/> Terminate/Cancel Existing Coverage <input type="checkbox"/> Annual Enrollment	2. Select one of the health plans below <input type="checkbox"/> BCBSMA HMO (Per month: \$297.05 IND / \$788.06 FAM) <input type="checkbox"/> BCBSMA PPO (Per month: \$544.57 IND / \$1,443.65 FAM) <input type="checkbox"/> Mass General Value HMO (Per month: \$246.48 IND / \$654.16 FAM)  <i>Rates listed above are effective 7/1/26 - 6/30/27</i>	4. Select coverage level <input type="checkbox"/> Individual <input type="checkbox"/> Family
		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

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

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

**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: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree	7. Home Phone  8. Work Phone

**Part 2 – Basic Life Insurance**

1. Check one: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change/Update Beneficiary <input type="checkbox"/> Cancel Policy	2. Select one of the coverage levels below <input type="checkbox"/> \$5,000 (Active & Retired Employees) <input type="checkbox"/> \$10,000 (Only available for certain Unions)	3. Effective Date
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**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
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