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

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. Home Address (Including Zip Code) | 6. Check one status: | 7. Primary Phone |
|---|---|---|
| | ☐ Active Employee<br>☐ Retiree<br>☐ Surviving Spouse<br>☐ COBRA | 8. Primary Email |

## Part 2 – Health Coverage

**1. Check one event:**

- ☐ New Enrollment **(Basic Life Insurance Form Mandatory)**
- ☐ Change Enrollment (Add/Remove Dep)
- ☐ Decline/Waive Coverage
- ☐ Terminate/Cancel Existing Coverage
- ☐ Annual Enrollment *(Effective 07/01/21)*

**2. Select one of the health plans below** *(monthly rate)*

- ☐ **AllWays Value HMO *** *(IND $154.57 / FAM $409.76)*
- ☐ **BCBS Standard HMO ***
  **Network Blue New England** *(IND $186.29 / FAM $493.61)*
- ☐ **BCBS PPO**
  **Blue Care Elect Preferred** *(IND $346.45 / FAM $918.06)*

*HMO plans require members to select a primary care physician (PCP) who will provide referrals to specialists and authorizations as needed. Contact your health plan to select a PCP.

**3. Select coverage level**

- ☐ Individual
- ☐ Family

**4. 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) |
|---|---|---|---|---|---|---|
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## 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:** _____

## 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 selected coverage.
**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 I am no longer eligible for City of Boston coverage if I do remarry.

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

| Signature of Applicant | Date | Signature of Authorized Official | Date |
|---|---|---|---|