City of Boston

Basic Life Insurance Enrollment Form

Policy Number – 25373

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

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)	2. Sex (M/F)	3. Date of Birth (mm/dd/yyyy)	4. SSN

5. Home Address (Including Zip Code)	6. Check one: ☐ Active Employee ☐ Retiree	7. Primary Phone / 8. Primary Email

Part 2 – Basic Life Insurance

1. Check one:	2. Select one of the coverage levels below	3. Effective Date
☐ New Enrollment ☐ Change/Update Beneficiary ☐ Cancel Policy	☐ $5,000 (Active & Retired Employees) ☐ $10,000 (Only available for certain Unions)	

Part 3 – Beneficiary Information

Primary Beneficiary: Designate at least one primary beneficiary for your policy. **If you designate more than one beneficiary, please be sure the total percentages of benefit equal 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.

Name (Last, First)	Sex (M/F)	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. Attach a separate sheet if additional space is required.

Name (Last, First)	Sex (M/F)	Relationship	Date of Birth (mm/dd/yyyy)	Home Address (Street, City, State, Zip)	Phone Number	% of Benefit

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 the Boston retirement system to be eligible for City of Boston coverage.

_____ _____

Signature of Applicant Date Signature of Authorized Official Date