City of Boston
Optional Life Insurance Enrollment Form
Policy Number – 25373

Employee ID: _____

Return completed form to
Health Benefits & Insurance Division
Boston City Hall, Room 807
Boston, MA 02201
Fax: 617-635-3932

Eligibility: Employees working a minimum of 20 hours per week. Employee must be enrolled in the $5,000 or $10,000 Basic to join this plan.

- This benefit is 100% employee paid. Active employees may elect insurance amounts equal to 1 x annual salary, minus $1,000. Amounts can be elected from $1,000 to a maximum of $74,000 based on the guidelines of Chapter 32B section 11A. See the optional life insurance rate table additional information about monthly rates.
- **Upon retirement, full benefit continues until age 75 at which time, all benefits terminate and conversion is available.**

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:** ☐ Active Employee ☐ Retiree	**7. Home Phone** **8. Work Phone**

Part 2 – Optional Life Insurance

1. Check one:
- ☐ New Enrollment
- ☐ Change/Update Beneficiary
- ☐ Change Amount
- ☐ Cancel Policy

2. Effective Date

3. Select one of the following:

☐ I hereby apply for my Maximum Allowable Insurance and Authorize Payroll Deductions as required. If I become entitled to further additional insurance because of an increase in annual salary, the premium for such additional insurance will be automatically deducted from my salary without my further approval.

☐ I desire only $_____ (fill in amount of insurance desired) of Optional Insurance. I do not desire additional insurance automatically based upon any increase in salary.

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