# City of Chelsea
# BASIC & VOLUNTARY LIFE

**How much insurance does the City offer me?**

The City of Chelsea offers employees the opportunity to purchase $5,000 of coverage and will pay 50% of the premium. While this is a great benefit, it may not cover all of your final expenses nor leave anything for your loved ones.

**How much more insurance can I buy?**

An employee may elect additional insurance in increments of $10,000, up to five times their salary, to a maximum of $500,000, with a guaranteed issue amount of $100,000, or $50,000 over the age of 60, without additional health questions.

**What are the costs?**

This insurance has age-banded rates but is based on issue age; therefore your premium will not increase as you get older.

**Should I wait until I'm older to sign up for this coverage?**

Each employee is offered one opportunity to sign up for this coverage, to certain limits, without having to submit medical evidence of insurability. This means, that in your first 30 days of employment, you could get up to $100,000 of insurance without having to answer any medical questions. When you get older, you may not be medically able to qualify.

**Can this policy be deducted from my paycheck as other benefits?**

Yes, the Optional Term Life Insurance also includes convenient payroll deductions.

**Can I cover my family also?**

Yes, you may cover your spouse and child(ren) to certain limits.

**How can I get more info?**

For more information, please contact Human Resources at (617) 466-4171.

# City of Chelsea
# EMPLOYEE LIFE OPTION PLUS (Permanent Life)

**When can I sign up?**

You are eligible to sign up for permanent life insurance within the first 30 days of employment, at a benefit fair or during a scheduled enrollment period.

**What is ELOP insurance?**

Whole Life Insurance at an affordable price. It combines guaranteed level premiums coverage and dividends that are so attractive in whole life insurance, with the advantages of cash accumulation at current interest rates.

**Does this plan replace my present group insurance?**

No. ELOP coverage is independent of and supplements your present group insurance program.

**What are the costs for the ELOP insurance?**

You choose the amount of insurance or the amount of premium that best suits your needs and budget. Weekly deductions range from $2 - $18/week for new employees. The maximum benefit is $200,000.

**Is there spousal coverage?**

Yes. The premiums would range between $3 - $5/week.

**How about dependent coverage?**

Insurance is available for unmarried dependent children age 15 days through age 25. Grandchildren are eligible from 15 days to age 15. Premiums range from $1 - $5/week, even if you choose not to buy insurance for yourself.

**Can I keep this policy if I leave employment?**

Yes, this policy is portable (YOU OWN IT). You can take your policy with you at the same rate as when you were an employee. The idea of Permanent Life Insurance is so that you can keep it when you leave employment.

Please contact LifePlus Insurance Agency, Inc. with any enrollment questions.
781-837-9222 – fax 781-837-9227

# CITY OF CHELSEA VOLUNTARY TERM LIFE AND AD&D RATES

Must have Basic Life to sign up for Optional Life

## ***ISSUE AGE OPTION***

**GUARANTEED ISSUE AMOUNTS**

| AGE | Under 60 | 60-69 | 70 & Over |
|---|---|---|---|
| Employee | $ 100,000 | $ 50,000 | $ 10,000 |
| Spouse | $ 30,000 | $ 20,000 | Not Eligible |
| Dependent | $ 10,000 | | |

## MONTHLY PREMIUM

| Age | Monthly Premium Rate per 1,000 | 10,000 | 20,000 | 30,000 | 40,000 | 50,000 | 60,000 | 70,000 | 80,000 | 90,000 | **100,000** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| <35 | $0.13 | $1.30 | $2.60 | $3.90 | $5.20 | $6.50 | $7.80 | $9.10 | $10.40 | $11.70 | $13.00 |
| 35-39 | $0.17 | $1.70 | $3.40 | $5.10 | $6.80 | $8.50 | $10.20 | $11.90 | $13.60 | $15.30 | $17.00 |
| 40-44 | $0.24 | $2.40 | $4.80 | $7.20 | $9.60 | $12.00 | $14.40 | $16.80 | $19.20 | $21.60 | $24.00 |
| 45-49 | $0.37 | $3.70 | $7.40 | $11.10 | $14.80 | $18.50 | $22.20 | $25.90 | $29.60 | $33.30 | $37.00 |
| 50-54 | $0.58 | $5.80 | $11.60 | $17.40 | $23.20 | $29.00 | $34.80 | $40.60 | $46.40 | $52.20 | $58.00 |
| 55-59 | $0.89 | $8.90 | $17.80 | $26.70 | $35.60 | $44.50 | $53.40 | $62.30 | $71.20 | $80.10 | $89.00 |
| 60-64 | $1.37 | $13.70 | $27.40 | $41.10 | $54.80 | $68.50 | $82.20 | $95.90 | $109.60 | $123.30 | $137.00 |
| 65-69 | $2.27 | $22.70 | $45.40 | $68.10 | $90.80 | $113.50 | $136.20 | $158.90 | $181.60 | $204.30 | $227.00 |
| 70-74 | $3.98 | $39.80 | $79.60 | $119.40 | $159.20 | $199.00 | $238.80 | $278.60 | $318.40 | $358.20 | $398.00 |

****EMPLOYEE MUST HAVE COVERAGE IN ORDER TO INSURE SPOUSE AND/OR CHILDREN****

- EMPLOYEE LIFE & AD&D = $10,000 TO A MAXIMUM OF $500,000 (NOT TO EXCEED 5 TIMES SALARY)
- SPOUSE LIFE & AD&D = $5,000 TO A MAXIMUM OF $100,000 (NOT TO EXCEED 50% OF EMPLOYEE BENEFIT)
- DEPENDENT (LIFE ONLY) = $1,000 AGE 14 DAYS TO 1 YEAR; $10,000 AGE 1 YEAR TO AGE 19 OR 25 IF FULL TIME STUDENT ($1.90/MONTH)
- DEPENDENT CHILD(REN) - (LIFE ONLY) COVERAGE ALL GUARANTEE ISSUE

Applicants requesting insurance amounts over the guaranteed issue amount will require an Evidence of Insurability Form and Authorization to Release Medical Information. These forms will need to accompany the application .

**BOSTON MUTUAL LIFE INSURANCE COMPANY**

[120 Royall Street • Canton, MA 02021 1-800-669-2668 Ext. 473]

# STATEMENT OF INSURABILITY FORM FOR GROUP INSURANCE

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

Refer to the Group Policy for types of coverage available and eligible amounts of insurance.

***PLEASE COMPLETE IN FULL***

**IMPORTANT**
Submit with completed Enrollment form.

## EMPLOYEE/EMPLOYER

| Group # | Div. # | Employer/Group Name |
|---|---|---|
| | | |

| Social Security # | Employee Name *(Last, First, Middle Initial)* |
|---|---|
| | |
| **Telephone #** | **Address** |
| | |

## PROPOSED INSURED(S)

| Name | Relationship | Date of Birth | Height | Weight *[(if pregnant, pre-pregnancy weight)]* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## REASON

**NEW**

- ❑ Late Applicant
- ❑ Applying for Coverage in Excess of the Guaranteed Amount
- ❑ Applying for Supplemental Coverage
- ❑ Other _____

**CHANGE**

- ❑ Increase in Coverage
- ❑ Adding Spouse
- ❑ Increasing Spouse
- ❑ Adding Dependent Child(ren)
- ❑ Other _____

## INSURANCE

| **YOU** | **[LIFE** | **AD&D** | **VOLUNTARY LIFE** | **VOLUNTARY AD&D]** |
|---|---|---|---|---|
| Current Insurance | [ | | | ] |
| Additional Insurance Requested | [ | | | ] |
| Total New Coverage | [ | | | ] |

- ❑ [Short Term Disability $ _____ ] *Weekly Benefit*
- ❑ [Long Term Disability $ _____ ] *Monthly Benefit*
- ❑ Other $ _____

| **YOUR SPOUSE** | **[LIFE** | **AD&D** | **VOLUNTARY LIFE** | **VOLUNTARY AD&D]** |
|---|---|---|---|---|
| Current Insurance | [ | | | ] |
| Additional Insurance Requested | [ | | | ] |
| Total New Coverage | [ | | | ] |

- ❑ Other $ _____

## EVIDENCE OF INSURABILITY

**Existing Coverage**

**Please list all life insurance and/or annuity contacts now in-force or pending on your life**

| Name of Company *(if replacement include Policy No.)* | Life Amount | AD&D Amount | Year Issued or Pending | Do you intend to replace or change this coverage if you and your dependents are approved for the insurance applied for on this application? |
|---|---|---|---|---|
| | | | | ❑ YES ❑ NO |
| | | | | ❑ YES ❑ NO |

**To be Completed for ALL Proposed Insured(s) if Required by the Group Insurance Contract**

1. Have you used any form of tobacco products *(cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches)* within the past 12 months? ** **Employee** ❑ YES ❑ NO **Spouse** ❑ YES ❑ NO

** ***I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted only for misstatement of age or sex.***

2. In the past [3-10 years], have ANY of the proposed insureds been diagnosed, treated, tested positive for or been given medical advice by a licensed medical professional that they had: A) sleep apnea, asthma or emphysema; B) high blood pressure, stroke chest pain, transient ischemic attack (TIA), heart or circulatory disease or disorder; C) intestinal disease or disorder or ulcer; D) diabetes; E) leukemia, cancer, tumor or malignancy; F) epilepsy, mental or nervous disease or disorder; G) kidney or genito-urinary disease or disorder; H) disorder of the back, muscles, bones or joints; I) liver disease or disorder; J) pancreatitis (new or acute); or K) thyroid disorder? ❑ YES ❑ NO
3. In the past 5 years, have ANY of the proposed insureds been treated for or been diagnosed by a licensed medical professional as having an immune deficiency disorder or AIDS (Acquired Immune Deficiency Syndrome)? ❑ YES ❑ NO
4. In the past 5 years, have ANY of the proposed insureds; 1) been hospitalized or had hospitalization recommended; 2) had a physical examination or medical test with other than normal results? ❑ YES ❑ NO
5. Within the next 2 years, do you or your spouse: A) fly, or intend to fly, as pilot or crew member; B) race or test drive any form of vehicle; C) scubadive; D) hang glide or sky dive? ❑ YES ❑ NO
6. Have ANY of the proposed insured, within the past [3-10 years], used or are they currently using or received treatment or consultation for the use of heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs or alcoholism? ❑ YES ❑ NO
7. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having memory loss? ❑ YES ❑ NO
8. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Amytrophic Lateral Sclerosis (ALS)? ❑ YES ❑ NO
9. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having autism? ❑ YES ❑ NO
10. In the past 2 years, have any of the proposed insureds been treated, examined or advised by a licensed medical professional for attempted suicide? ❑ YES ❑ NO
11. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Huntington's Chorea? ❑ YES ❑ NO

**[To be Completed if Applying for Disability Insurance**

12. Are ANY of the proposed insureds currently pregnant? ❑ YES ❑ NO]

Details for questions [2-12] answered "YES". Include question number. *(Attach additional details on a signed and dated separate sheet)*

| Name | Medical Condition | Date(s) | Details/Treatment | Name & Address of Attending Physicians and Hospitals |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## AUTHORIZATION TO OBTAIN INFORMATION

**MIB PRE-NOTICE**

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. *(formally known as Medical Information Bureau, Inc.)*, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

**MIB REPORTING AUTHORIZATION**

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

**CONSUMER REPORTING AUTHORIZATION**

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report, which may include a report from MIB, Inc. *(formerly Medical Information Bureau, Inc.)* on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

## REPRESENTATIONS AND NOTICE TO APPLICANTS

I/we have read the Statement of Insurability form and represent that the statements and answers are complete and true to the best of my/our knowledge and belief. I/we agree that this form shall form the basis for and become a part of the consideration for the insurance applied for.

CAUTION: Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

| Signature of Proposed Insured *(Employee/Member)* | Date | Signed & Dated at *(City, State)* |
|---|---|---|
| Signature of Proposed Insured *(Other than Employee/Member)* *(Employee/Member if the proposed insured is under [15])* | Date | Signed & Dated at *(City, State)* |

**MUST BE USED WITH HIPAA FORM DESIGNATED FOR YOUR STATE**

**BOSTON MUTUAL LIFE INSURANCE COMPANY** **1-800-669-2668 x700**

**120 Royall Street • Canton, MA 02021**

*PLEASE PRINT OR TYPE*

***Please refer to your Administration Kit for enrollment and mailing instructions***

# GROUP BENEFITS ENROLLMENT FORM

## EMPLOYEE / FAMILY INFORMATION

Employer/Policyholder _____ Dept. ID _____

Employee Name *(Last, First, Middle)* _____ Social Security Number _____

Home Address *(Street, City, State, Zip)* _____ ( ) Telephone # _____

Gender *(M/F)* _____ Occupation or Job Title _____ Date of Birth _____ Age _____ PAYROLL TYPE: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Annual Earnings: $ _____

Average Hours Worked _____ Date of Hire _____ or Date of Full Time Employment if different _____ Effective Date _____ State _____ Class _____

Spouse *(Last, First, Middle)* _____ Gender *(M/F)* _____ Date of Birth _____ Age _____ No. of Dependents _____

## LIFE

**You Must Have Basic Coverage to Elect Voluntary Coverage**

**BASIC:**

**Group #** 26213 **Div.** _____

| | YES | NO | Insurance Amount |
|---|---|---|---|
| LIFE & AD&D | ❑ | ❑ | $ 5,000 |

**You Must Have Voluntary Coverage to Elect Dependent Coverage**

**VOLUNTARY:**

**Group #** 26840 **Div.** _____

| | YES | NO | Insurance Amount |
|---|---|---|---|
| LIFE & AD&D | ❑ | ❑ | $ _____ |
| SPOUSE | ❑ | ❑ | $ _____ |
| **DEPENDENT LIFE:** | | | |
| CHILD(REN) | ❑ | ❑ | $ _____ |

## BENEFICIARY

**Name of Your Beneficiary(ies) for Life and/or AD&D Benefits:** *(Total Percentage of Benefit must equal 100%)* **List Additional Beneficiaries on separate sheet**

| Primary Beneficiary(ies): | Residential Address | Date of Birth | Social Security # | Tel. # | Relationship | % of Benefit |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| **Contingent Beneficiary(ies):** | | | | | | |
| | | | | | | |
| | | | | | | |

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. If an insured dependent dies, we will pay the proceeds to you.

## ACCEPTANCE OF INSURANCE - *Employee Signature Required*

## SIGNATURE

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.* I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

**Signature of Employee** _____ **Date** _____

## REFUSAL OF INSURANCE

Employee Name _____ *(Last, First, Middle)* Employee/Policyholder _____ Group No. _____

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer *(or the Association with whom I am affiliated)* and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

❑ Basic Life & AD&D ❑ Voluntary Life & AD&D ❑ Dependent Life

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____

**BOSTON MUTUAL LIFE INSURANCE COMPANY**
120 ROYALL STREET · CANTON, MASSACHUSETTS 02021 · 800-669-2668

## Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY

***(This authorization complies with the HIPAA Privacy Rule)***

Name of *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

Name of Second *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

**I authorize any** health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *("Providers")* that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes.**

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization,** and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

**This protected health information is to be disclosed under this Authorization so that BML may:** 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

**This authorization shall remain in force for 24 months** following the date of my signature below, and a copy of this authorization is as valid as the original. **I understand that I have the right to revoke this authorization in writing,** at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient

### • DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____ , the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured _____ Date _____