MUNICIPAL HEALTH BENEFIT FUND

☐ COBRA ENROLLMENT

☐ DEPENDENT COBRA ENROLLMENT

Group No. _____

(THIS FORM MUST BE COMPLETED BY THE MEMBER AND ACCOMPANY THE FIRST MONTH'S PREMIUM PAYMENT. ALL PREMIUM PAYMENTS MUST BE MADE THROUGH THE EMPLOYER'S OFFICE . ALL PREMIUMS SENT DIRECTLY TO THE FUND WILL BE RETURNED AND A LATE PENALTY MAY APPLY.)

PLEASE REFER TO THE BACK OF THIS APPLICATION FOR IMPORTANT INFORMATION

SSN	Group Name		Group Number	
Last Name	First Name	MI	Date of Birth	Sex
Mailing Address	City		State	Zip
Phone Number	Marital Status ☐ Single ☐ Married ☐ Divorced	COBRA Effective Date	COBRA End Date (Fund Use)	

Type of Coverage Desired:

☐ I am WAIVING my right to continuation coverage under the COBRA plan.

☐ I elect to continue SINGLE coverage under the COBRA plan.

☐ I elect to continue FAMILY coverage under the COBRA plan.

If you are electing Dependent COBRA, please list the name and SSN of the member you are transferring from

Dependent Section Below: Only qualified beneficiaries who had family coverage before the event may elect family coverage, with the exception of Dependent COBRA Members.

Dependent Name	Sex (M/F)	Social Security No. of Dependent	Date of Birth	Relationship *(Options Below)	Other Ins. (Y/N)

***RELATIONSHIP OPTIONS: S= SPOUSE C = CHILD SC = STEP-CHILD AC = ADOPTED CHILD**

If YOU have Medicare or additional health coverage please list below

Group Name	Policy Number	Effective Date	Policy Holder

If your DEPENDENTS have Medicare or additional health coverage please list below

Group Name	Policy Number	Effective Date	Policy Holder

COBRA MEMBERS ARE NOT ELIGIBLE FOR LIFE AND AD&D BENEFITS

Signature of Member **Date Signed**

ATTENTION EMPLOYER: Send this form along with the COBRA premium to: Plan Administrator, Municipal Health Benefit Fund c/o MHBF Premium Clerk, PO Box 55152, Little Rock, AR 72215

Rev.09/06