

# MUNICIPAL HEALTH BENEFIT FUND RETIREE COVERAGE ENROLLMENT APPLICATION

## EMPLOYER SECTION

(This section must be completed by the Employer before submitting to MHBF)

Name of City/Entity

Group Number

Date of Retirement

Years of Service at time of Retirement

Effective Date (MOB Use)

The above member is vested in the retirement system of (List Municipality):

## MEMBER/RETIREE SECTION

SON

Last Name

First Name

MI

Mailing Address

City

State

Zip

Phone Number

(       )

Sex

Marital Status

Single  Married  Divorced

Date of Birth

Age at Retirement

Type of Coverage Desired

Single Only  Family

## DEPENDENT SECTION BELOW

(Please complete this section ONLY if you had family coverage at the time of your retirement)

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

**Benefits Available** - A member retiring under this status will be eligible for all provisions of the standard benefit plan as described in the Fund Booklet, with the exception of the following coverage's: Life, ADD and Disability Income. For covered members who are totally disabled or reach age 65 and are eligible for Medicare and fail to apply for Medicare in a timely fashion, the Municipal Health Benefit Fund will coordinate with Part A, Part B and Part D of Medicare the same as if the covered member has Part A, Part B and Part D of Medicare.

**Pharmacy Benefits** - Enrollment in Medicare Part D coverage is required in order to be eligible for this benefit supplement.

**Please note: A completed Multiple Coverage Inquiry form MUST accompany this Retiree Coverage Enrollment Application for your enrollment in Retiree coverage to be processed.**

Employee's Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

When any municipal official or municipal employee is age fifty-five (55) or older, has completed twenty (20) years of service with a Participating Employer and is vested in the Participating Employer's properly sanctioned retirement system, and retires from the Arkansas municipality, the retiree may then continue to participate in the Municipal Health Benefit Fund receiving the same medical benefits and paying the same premium as active employees, as long as the retiree pays the total premium due to Municipal Health Benefit Fund. By Signing this form, you (as the Group Representative) are verifying that the above member meets all of these requirements and is eligible to continue his/her coverage under the Retiree Status.

Signature of Group Representative \_\_\_\_\_

Date Signed \_\_\_\_\_