

MUNICIPAL HEALTH BENEFIT FUND

ENROLLMENT APPLICATION

(Mark the box below for the reason this form is being submitted)

- New Enrollment
 Return from Military Leave*
 Elected Officials D/D/V Only**
 Retiree (years of service: _____ / Vested In _____)
 Refusal of Benefits

EMPLOYER SECTION - This section must be completed by the Employer Representative before submitting to MHBF

Employee SSN		Name of Employer		Group Number
Full-Time Date of Hire	Effective Date (MHBF Use)	History Date (MHBF Use)		
Please check the applicable Eligible Class of the Employee				
<input type="checkbox"/> Elected Official _____ (office)		<input type="checkbox"/> Member of _____ Board/Commission		
<input type="checkbox"/> Volunteer Fire Fighter		<input type="checkbox"/> Auxiliary Police		<input type="checkbox"/> Full Time Active Employee _____ (Working at least 30 hours per week) Full-Time Position Held
Life Amount	AD&D Amount	Option A Disability Income <input type="checkbox"/> Yes <input type="checkbox"/> No	Option B Disability Income <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEMBER/EMPLOYEE SECTION

Employee SSN		Last Name		First Name		MI
Mailing Address		City		State	Zip	Phone Number ()
Sex	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Date of Birth / /		Type of Coverage Desired <input type="checkbox"/> Single Only <input type="checkbox"/> Family	

DEPENDENT SECTION BELOW

(Please complete this section ONLY if you are enrolling Family Coverage on this form.)

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

**Persons enrolling in Elected Officials D/D/V Only or Retirees coverage are NOT eligible for Life, AD&D or Disability Income Benefits.

*** If this form is being submitted as a Return from Military Leave form please list the date the employee returned to work in the 'Full-Time Date Time Date of Hire' area.

I hereby accept the form(s) of Group Life, AD&D, Dependent Life and Medical Benefits presently contracted for by my employer with the Municipal Health Benefit Fund in the amount(s) for which I am or may become eligible and authorize until revoked by me in writing the deduction by my employer from my earning of amounts sufficient to cover my contribution towards the premium under the said Municipal Health Benefit Fund.

Member/Employee's Signature	Date Signed
Employer Representative:	
I am including the following documents that are required to process an employee and/or dependent(s)	
CERTIFICATE OF ACCEPTANCE OF PLAN PROVISIONS (pg.1 of current year benefit booklet)	<input type="checkbox"/> YES <input type="checkbox"/> NO
MULTIPLE COVERAGE INQUIRY FORM (and any additional documentation required by this form)	<input type="checkbox"/> YES <input type="checkbox"/> NO
(If these forms have been previously submitted for the current year, they will not be required to be re-submitted with this form)	

MHBF USE ONLY

Signature of Employer Representative	Date Signed
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PLEASE SEE CURRENT MHBF BOOKLET FOR ADDITIONAL INFORMATION REGARDING ENROLLMENT AND/OR CHANGES IN COVERAGE