

Notice to Municipal Health Benefit Fund of the Termination of Health Coverage

(This form is required to terminate coverage on a covered employee and/or covered dependent. This completed form, indicating the "Qualifying Event for COBRA Continuation Coverage" or reason for the loss of coverage is required for the employee and/or dependent(s) to be eligible for "Continuation Coverage" under COBRA.) Please submit the completed form the Plan Administrator of the Municipal Health Benefit Fund at the address or fax number listed below as soon as possible.

Date of Notice: _____

To: Plan Administrator
Municipal Health Benefit Fund
Attention: Premium Clerk
P O Box 55152
Little Rock, AR 72215
Fax# 501-537-7252

From: _____

(Employer)

(Address)

RE: (Member/Employee) _____

(SSN#) _____ (Group Name) _____

The information requested below is required to comply with Federal COBRA regulations regarding the notification of the loss of coverage. If coverage is being terminated on an employee **and** all dependents one form may be submitted for the family.

Name of Person Losing Coverage

Social Security Number

Mailing Address for COBRA Notice

City

State

Zip

* COBRA Notices are mailed to every person who loses their coverage with the Municipal Health Benefit Fund

On _____ (date), the above listed employee and/or dependent(s) had the following event that did/will cause their coverage with the Municipal Health Benefit Fund to end:

- Termination of employment
- Reduction in hours of employment
- Death of employee (member)
- Employee's (member's) Medicare entitlement
- Employee's (member's) Refusal of Benefits
- Dependent's Medicare entitlement
- Divorce or legal separation
- Ceased to be a dependent child as defined under the Plan
- Other _____

Coverage will terminated on the last day of:

(Month)

(Year)

Signature of Group Representative

Title

(Rev. 2008)

PLEASE SEE 'WHEN YOUR BENEFITS STOP' IN THE CURRENT MHBFB BOOKLET FOR ADDITIONAL INFORMATION.