

## Acknowledgement of Receipt

I hereby acknowledge that I have received a copy of the following Notifications from my employer.

- HIPAA Privacy Notice
- Health Insurance Marketplace Coverage Options Notice and the
- Summary of Benefits and Coverage for the 20\_\_ \_\_ Fund Year

I also acknowledge that I may also access these Notifications at:

<http://www.arml.org/services/mhbf/>

\_\_\_\_\_  
Employee's Name (please print)

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

\_\_\_\_\_  
Date

**Do not send to MHBF – this must be returned to your employer.**