MUNICIPAL HEALTH BENEFIT FUND

☐ COBRA ENROLLMENT **(Single and Family)**

☐ DEPENDENT COBRA ENROLLMENT

(If enrolling in Dependent COBRA please complete form using the Dependent's name and SSN)

☐ EXTENDED COBRA ENROLLMENT *

This form is to be completed by the member or dependent electing COBRA or Extended COBRA coverage.

SSN	**Name of City/Entity**		**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 choose** SINGLE **coverage under the COBRA plan.**

☐ **I choose** FAMILY **coverage under the COBRA plan.**

☐ **I choose** EXTENDED **COBRA* coverage (Please see below for additional information)**

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

If you are enrolling Family Coverage on this form please list the dependents you wish to cover below
Only persons who had family coverage prior to enrolling COBRA may enroll 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**

EXTENDED COBRA* ONLY PLEASE NOTE:

Only persons who have been determined to be disabled by the Social Security Administration and their onset date of disability is prior to or within the first sixty (60) days of the original eighteen (18) month COBRA period are eligible for Extended COBRA coverage. This completed Extended COBRA coverage enrollment form and proof of the onset date of disability must be received prior to the end of the original eighteen (18) month COBRA period.

COBRA MEMBERS ARE NOT ELIGIBLE FOR LIFE AND AD&D BENEFITS. PLEASE SEE THE CURRENT YEAR MHBF BENEFIT BOOKLET FOR ADDITIONAL INFORMATION REGARDING COBRA CONTINUATION COVERAGE.

Signature of Member **Date Signed** **MHBF USE ONLY**

Mail form and payments to:
MHBF Premiums
PO Box 880
Conway, AR 72033

(Rev. 2018)