Certificate of Notice and Acceptance of Plan Provisions

Public Health Service Act Exemptions
Continuation of Coverage (COBRA)
Beneficiary Designation
Effective December 1, 1981 (as Amended Each Plan Year)

You must sign this form on your behalf and your dependents.

You must return this signed form to your employer.

If you do not sign and return this form to your employer the Fund will not provide you or your dependents with coverage.

When you sign the form you are agreeing that you have received a copy of the Privacy Notice and the Summary of Benefits and Coverage (SBC). These are two separate documents.

By signing the form you also acknowledge that you may obtain a copy of the Municipal Health Benefit Fund Booklet at www.arml.org/mhbf and that you agree to accept the terms and conditions of the Municipal Health Benefit Fund.

The Fund's Plan is subject to Federal law, including, the Patient Protection and Affordable Care Act and the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA). COBRA provides for the extension of coverage under the Plan should certain special life events take place. (See the Declaration of Trust on page 1 of the Fund Booklet for more information).

Federal law also allows the Fund to exempt the Fund from some requirements imposed by Federal law. The Fund has done so. (See page 1.)

You further acknowledge that although the Plan may have provided benefits for an illness or condition in past years, the Plan does not necessarily provide benefits for those illnesses or conditions in subsequent Plan years.

By signing below you authorize any hospital, physician or health care provider and/or payer to furnish any information requested by the Municipal Health Benefit Fund that may be necessary to determine benefits payable.

Your authorization for the release of records to determine benefits payable also provides for the release of records of your eligible covered dependents. Your authorization shall remain in effect until changed or updated by you or the Plan. An electronic or photo-static copy of this authorization shall be considered effective and valid as the original for purposes of medical authorization only.

You may revoke your medical authorization on your behalf or that of your eligible covered dependent by providing a written revocation to the Fund.

If you or your eligible dependent(s) changes their coverage status by dropping coverage or changing coverage to a different group then a new certificate must be signed. All new employees are required to execute this Certificate of Notice and Acceptance of Plan Provisions.

Member/Employee: _____ _____
Signature of Member (Includes Retiree or COBRA Member) Social Security Number

Member/Employee: _____ _____
Print Your Full Member Name Date of Birth

Home Telephone Number: _____ Date Signed: _____

Please list a Beneficiary and their relationship to you for your Life Benefits

Beneficiary: _____ _____
Print Name Clearly S=Spouse C=Child SC=Step Child AC=Adopted Child

Beneficiary's Date of Birth _____

This portion is to be completed by Employer Representative and mailed to:
Municipal Health Benefit Fund, P.O. Box 188, North Little Rock, AR 72115

City/Entity of: _____

Group Representative: _____

Save Form

Print Form

Clear Form

MHBF USE ONLY

This form should be returned to your Employer.