

Municipal Health Benefit Fund

Enrollment/Change/Termination Form

Employee Information - All Fields Required

Group Number: _____

Group Name:	Social Security Number:
Date of Birth:	Gender: Male / Female
First Name:	Last Name:
Full Address (street, city, state, zip code):	

Phone: (____) _____

Marital Status: Single _____ Married _____ Divorced _____ Effective Date: _____

Active Member: Full Time Hire Date _____ Full Time Employee (position held) _____

Retiree Member (years of service _____ / Vested in _____)

Elected Official _____ (office) Member of _____ Board/Commission

Volunteer Fire Fighter _____ Auxiliary Police _____

Life Amount	AD&D Amount	Option A Dis.	Option B Dis.
YES	NO	YES	NO

What do you want to do?

- Enroll in the plan
 - Refusal of Benefits
 - Add/Drop a dependent from your plan
 - Cancel coverage: Cancel Date _____ Termination of employment / Reduction in hours / Member Death / Medicare
 - Change coverage: Single to Family _____ Family to Single _____ Remove Spouse _____ (date of divorce)
- Change Beneficiary _____ Change Name _____

- Return from Military Leave
- Elected Officials D/D/V Only**

Supporting Documentation MUST be submitted for changes.

What level of coverage do you want?

- Employee Only
- Family

Please check with your City Clerk or HR Dept. to be sure what Options are available to you through your Employer

- ~~Life and AD&D~~ Dental ~~Vision~~ (Employee level)
- ~~Life and AD&D~~ Dental ~~Vision~~ (Family level)

Add/Drop	Name	Date of Birth	Social Security Number	Male/Female	Relation	Other Ins. yes or no	Reason for Change

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.

Employee Signature: _____ Date: _____

(Employee signature not required for termination)

Group Rep. Signature: _____ Date: _____

MHBF use only