Municipal Health Benefit Program

Enrollment/Change/Termination Form

Employee Information - All Fields Required Group Number:

Group Name:	Social Security Number:
First Name:	Last Name:
Date of Birth:	Gender: Male / Female (circle one)
Full Mailing Address:	

Phone: (_____) _____

Marital Status: Single_____Married_____Divorced_____

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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_____

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)

☐ **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

☐ Dental Deductible: ☐ $500 ☐ $1,200

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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 Program 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 Program.

Employee Signature:_____**Date:** _____

(Employee signature not required for employment termination)

Group Rep. Signature:_____**Date:** _____

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