Effective Date:
MHBP Use Only

Municipal Health Benefit Program

Beneficiary Form

Employee Information - All Fields Required Group Number: Group Name:

Employee First Name:	Employee Last Name:
Social Security Number:	Date of Birth:
Marital Status: Married / Single / Divorced (circle one)	Gender: Male / Female (circle one)
Full Mailing Address:	

Phone: (_____) _____ Email: _____

Primary Beneficiary 1:

First Name:	Last Name:
Date of Birth:	Relationship:
Percentage of Benefit:	
Effective Date:	

Primary Beneficiary 2 (optional):

First Name:	Last Name:
Date of Birth:	Relationship:
Percentage of Benefit:	
Effective Date:	

Contingent Beneficiary 1 (optional):

First Name:	Last Name:
Date of Birth:	Relationship:
Percentage of Benefit:	
Effective Date:	

Contingent Beneficiary 2 (optional):

First Name:	Last Name:
Date of Birth:	Relationship:
Percentage of Benefit:	
Effective Date:	

Employee Signature: _____ **Date:** _____

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

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Eff 01.2022