Coverage Effective Date: _____

MHBP Use Only

Municipal Health Benefit Program

Enrollment 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: _____

Active Employee: Full Time Hire Date_____ Full Time Position Held_____

Elected Official_____(office) Member of_____Board/Commission

Volunteer Fire Fighter_____Auxiliary Police_____

What do you want to do?

☐ **Enroll** in the plan ☐ Employee Only ☐ Family

☐ **Return** from Military Leave

☐ **Refusal** of Benefits

☐ **Elected Officials D/D/V Only**

This information MUST be completed in order for form to be processed. DO NOT LEAVE BLANK

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

Dependent Information:

Name	Date of Birth	Social Security Number	Gender	Relation	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 is required)

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

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