MUNICIPAL HEALTH
P.O. BOX 188
NORTH LITTLE ROCK, ARKANSAS 72115
PHONE 501.978.6137 FAX 501.537.7252 www.arml.org

MUNICIPAL HEALTH

DATE TO BE EFFECTIVE: _____ Municipal Health Use Only

GROUP NAME: _____ GROUP NUMBER: _____

MUNICIPAL HEALTH BENEFICIARY FORM

EMPLOYEE INFORMATION - All fields Required

Last Name _____ First Name _____ SSN# _____

Address _____ City _____ State ___ Zip _____

Home Phone _____ Work Phone _____ Email _____

Marital Status: Single ☐ Married ◯ Divorced. ◯ **Gender:** Male ☐ Female ◯

Primary Beneficiary 1:

Last Name _____ First Name _____

Date of Birth _____ Relationship _____ Percentage of Benefit: _____ Effective Date:_____

Primary Beneficiary 2 (optional):

Last Name _____ First Name _____

Date of Birth _____ Relationship _____ Percentage of Benefit: _____ Effective Date:_____

Contingent Beneficiary 1 (optional):

Last Name _____ First Name _____

Date of Birth _____ Relationship _____ Percentage of Benefit: _____ Effective Date:_____

Contingent Beneficiary 2 (optional):

Last Name _____ First Name _____

Date of Birth_____ Relationship _____ Percentage of Benefit: _____ Effective Date:_____

Signature: _____ Date: _____

Group Rep. Signature: _____ Date: _____

Group Rep. Print Name: _____