

# Certificate of Notice and Acceptance of Plan Provisions

## Public Health Service Act Exemptions Continuation of Coverage (COBRA) Beneficiary Designation

Effective December 1, 1981 (as Amended January 1, 2015)

This mandatory Certificate of Notice must be signed by all covered members and spouse, if applicable, and then returned to the Employer Member of the Trust.

By signing below, I hereby certify that I have received a copy of the 2015 Municipal Health Benefit Fund's Privacy Notice as well as the Summary of Benefits and Coverage (SBC) and that I accept the terms and conditions of the Municipal Health Benefit Fund. I further understand that I may obtain a copy of the Municipal Health Benefit Fund Booklet at [www.arml.org/documents/Health\\_Fund\\_Booklet\\_2015WEB.pdf](http://www.arml.org/documents/Health_Fund_Booklet_2015WEB.pdf)

I acknowledge the Fund's election to exempt the Plan from certain requirements of Federal law and that the Plan recognizes and complies with all extended coverage benefits required by the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA).

By signing below, I further acknowledge that although benefits for an illness or condition may have been covered under a previous Plan Year booklet, the Plan does not necessarily provide benefits for those illnesses or conditions in a succeeding Plan Year. I hereby authorize any hospital, physician or health care provider and/or payer to furnish any information requested by the Municipal Health Benefit Fund that may be necessary to determine benefits payable. This authorization extends to the release of information required to determine benefits payable for my dependents under the age of majority. A photostatic copy of this authorization shall be considered effective and valid as the original for purposes of medical authorization only. This medical authorization shall remain in effect until such time that I revoke it in writing.

Member/Employee: \_\_\_\_\_  
Signature of Member (Includes Retiree or COBRA Member) Social Security Number

Member/Employee: \_\_\_\_\_  
Print Your Full Member Name Date of Birth

Home Telephone Number: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Spouse: \_\_\_\_\_  
Signature of Spouse (if applicable) Spouse Social Security Number

Spouse: \_\_\_\_\_  
Print Name of Spouse (if applicable) Spouse Date of Birth

Home Telephone Number: \_\_\_\_\_ Date Signed: \_\_\_\_\_

This portion is to be completed by Employer Representative and mailed to:  
Municipal Health Benefit Fund, P.O. Box 188, North Little Rock, AR 72115

City/Entity of: **City of Little Rock**

Group Representative: **Alicia Jacobs, SR Benefits Analyst**

MHBF USE ONLY

This form should be returned to your Employer.