The City of New York

Office of Labor Relations
Management Benefits Fund

22 Cortlandt Street, 28th Floor, New York, NY 10007
Tel: (212) 306-7290 /Fax: (212) 306-7353
nyc.gov/mbf

Renee Campion
Commissioner
Daniel Pollak
First Deputy Commissioner
Nicole Andrade
General Counsel

Georgette Gestely
Director, Employee Benefits Program
Beth Kushner
Deputy Director, Administration
Sang Hong
Deputy Director, Operations

September 19, 2025

Dear Management Benefits Fund (MBF) COBRA Enrollee:

Listed below are the new monthly MBF COBRA premium rates effective as of October 01, 2025 and will remain in effect until further notice.

Coverage	Individual	Family
SMMP Only	$16.68	$44.26
DENTAL & VISION	$56.92	$128.67
SMMP, DENTAL & VISION	$73.60	$172.93

These rate adjustments conform to the Federal provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and IRS regulations, which provide for periodic modification of rates due to changes in the experience cost of MBF group benefits contracts.

If you need further COBRA information, please visit MBF website at NYC.gov/mbf . If you need further question in reference to billing information, please contact ASO at 1-877-844-7667.

Sincerely,

City of New York
Management Benefits Fund

THIS COBRA APPLICATION IS NOT FOR COBRA CONTINUATION OF CITY HEALTH PLAN COVERAGE

The City of New York

OFFICE OF LABOR RELATIONS

Management Benefits Fund

Tel: (212) 306-7290 (888) 4000-MBF (outside NYC) / TTY: (212) 306-7629 / Fax: (212) 306-7353

Forms and documents can be submitted electronically to: https://nyc-mbf.leapfile.net

Consolidated Omnibus Budget Reconciliation Act (COBRA) Application for continuation of the Superimposed Major Medical Plan (SMMP) and/or Dental and Vision Care Benefit Programs

I. REASON FOR SUBMISSION (PLEASE PRINT) (CHECK ONE)

☐ New Enrollment ☐ Cancellation of COBRA ☐ Termination of Employment/Member ☐ Reduction of Work Schedule Date of Qualifying Event

☐ Divorce or Separation ☐ Death of Employee/Retiree ☐ Loss of Dependent Eligibility ☐ Termination of Domestic Partnership / /

If applicant other than present or former member } Relationship to present or former member ☐ Spouse ☐ Domestic Partner ☐ Son ☐ Daughter

Present or former member: Social Security Number

Last Name First Name MI.

II. APPLICANT INFORMATION (PLEASE PRINT)

Last Name First Name MI.

Social Security Number Date of Birth (MM/DD/YY) / / Sex ☐ Male ☐ Female Home Telephone Number - -

Mailing Address Apt.

City State Zip + Four +

Date of event / /

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Widowed ☐ Divorced ☐ Legally Separated

Is applicant eligible for or covered by another group policy? ☐ Yes ☐ No

III. PLEASE LIST ALL PERSONS TO BE CONTINUED, INCLUDING EMPLOYEE IF APPLICABLE (PLEASE PRINT) (CHECK ONE)

First Name	Last Name (if different)	Social Security Number	Date of Birth	Check if Applicable: Relationship: Self	Spouse	Domestic Partner	Son	Daughter	Status: Full-Time Student	Permanently Disabled	Covered by Other Group Insurance
				☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐

IV. COBRA ELECTION

I request COBRA coverage of Fund benefits as follows (Check one):

☐ Dental and Vision Care Only (Premium Branch 998)

☐ Superimposed Major Medical Plan* only (Premium Branch 997)

☐ Superimposed Major Medical Plan*, Dental, and Vision Care (Premium Branch 999)

* If you elected SMMP COBRA, please fill in your primary health coverage information to the right.

Name of City/Other Group Health Plan:

Prescription Drug Rider: ☐ Yes ☐ No

☐ I have no primary Health Plan Coverage (Please Note: SMMP; Deductible $10,000 per individual/$30,000 per family)

V. AUTHORIZATION

I certify that the above information is correct and understand that I am responsible for the full cost of Fund coverage and will be subject to the terms and conditions of Fund group contracts. I understand that I must submit this application within 60 days from the date of the Qualifying Event.

Applicant Signature: _____ Date / /

MBF CERTIFICATION (FOR OFFICE USE ONLY)

Coverage (Check One): ☐ Individual ☐ Family Monthly Premium Rate $

Certified by:	Title:	Date
		/ /

Print Form Clear Fields