The City of New York

Office of Labor Relations
Management Benefits Fund

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September 19, 2025

Dear Management Benefits Fund (MBF) Direct Pay Coverage Continuation (DPCC) for Young Adult Dependent (YAD) Child Enrollee:

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

Coverage	Individual
SMMP	$10.34
DENTAL & VISION	$38.71
SMMP, DENTAL & VISION	$49.05

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

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

MBF DIRECT PAY COVERAGE CONTINUATION (DPCC) FOR YOUNG ADULT DEPENDENT ENROLLMENT FORM

for the continuation of the Superimposed Major Medical Plan (SMMP) and/or Dental and Vision Care Benefit Programs

Prior to completing this Enrollment Form, please be sure the Young Adult Dependent meets the eligibility requirements on the reverse side of this form. This form is to be used per individual. Please do not include payment with this form. You will receive a monthly bill from the MBF DPCC billing administrator.

MEMBER INFORMATION (MUST BE AN ACTIVE MEMBER OF MBF)

SSN: ___ - ___ - ____ Date of Birth: __ / __ / ____ Telephone ___ - ___ - ____

Last Name: First Name: MI.:

Mailing Address - Number and Street: Apt:

City: State: Zip + Four: +

☐ Active Member ☐ Retired Member Agency/Former Agency (IF RETIREE):

YOUNG ADULT DEPENDENT INFORMATION (AGES BETWEEN 26 THROUGH 29)

If your Young Adult Dependent has never been enrolled in MBF due to ineligibility as a result of his or her age, you must provide a copy of the Young Adult Dependent's birth certificate in order to add him or her as your dependent under MBF.

☐ New Enrollment ☐ Cancellation (effective the1st day of the following month after the form is received by MBF)

SSN: ___ - ___ - ____ Date of Birth: __ / __ / ____ Relationship to Member

Last Name: First Name: MI.:

Mailing Address - Number and Street: ☐ Check here if the address is the same as above. Apt:

City: State: Zip + Four: +

DPCC OPTION - CHECK ONE

☐ SMMP*, Dental and Vision Care ☐ Dental and Vision Care only ☐ SMMP* only

* If you elect SMMP DPCC, please fill in the Young Adult Dependent's primary health coverage information:

Name of City/Other Group Health Plan: ***or*** ☐ None

Note: If the Young Adult Dependent does not have any primary health plan coverage, the SMMP deductible will be $10,000/Individual.

Prescription Drug Rider: ☐ Yes ☐ No (Note: If no drug rider, the SMMP deductible will be $2,500/Individual)

ACKNOWLEDGMENT

I, as the Young Adult Dependent, certify that I meet the eligibility requirements as stated above and that the above information is complete and correct. I agree that I will be fully responsible for payment of premiums due with respect to the DPCC coverage being requested as of the effective date.

Young Adult Dependent Signature: Date: __ / __ / __

I, as the MBF member, understand that any person who knowingly and with intent to defraud any insurance company or other persons who file an application for insurance or statement of claims containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

MBF Member Signature: Date: __ / __ / __

MBF Certification (For Office Use Only)

Coverage (CHECK ONE)	☐ SMMP, Dental and Vision Care	Certified by:	
	☐ Dental and Vision Care	Title:	
	☐ SMMP	Date Processed: __ / __ / __	
Monthly Premium Rate:	$	HealthPlex Group Number:	
Effective Date: __ / __ / __		End Date: __ / __ / __	

Print Form Clear Fields