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

September 2022

This Management Benefits Fund (MBF) COBRA information and application is for use only for the MBF member or the member's dependent when electing continuation of the below-indicated MBF Benefit Programs under COBRA. To request COBRA City health plan coverage information and an application, you should contact your agency human resources department or NYCAPS at (212) 487-0500. You may also visit the OLR Health Benefits Program Web site at nyc.gov/hbp.

Dear MBF Member or Member's Dependent:

You have the option to continue coverage of some or all of the MBF benefit plans under the provisions of the Consolidated Omnibus Budget Reconciliation Act (Public Law 99-2721, Title X), also known as COBRA. These options are:

1. You may elect continuation in the MBF Superimposed Major Medical Plan (SMMP), Dental, and Vision Care Benefit Plans below, at the monthly premium specified.

	Individual	***Family***
SMMP, Dental & Vision Care	$56.73	$131.43

2. You may elect continuation in the MBF Dental and Vision Care Benefit Plans below, at the monthly premium specified.

	Individual	***Family***
Dental & Vision Care	$42.88	$94.56

3. You may elect continuation in the MBF SMMP below, at the monthly premium specified.

	Individual	***Family***
SMMP only	$13.85	$36.87

Please Note: If you do not have primary health coverage through the City or other group health plan, the SMMP deductible is $10,000 per individual/$30,000 per family.

For information regarding COBRA coverage under your City health insurance plan, please visit the Management Benefits Web site at www.nyc.gov/mbf.

If you have any questions, please contact MBF via email at the link below:
https://www1.nyc.gov/site/olr/webforms/send-message-management-benefits-fund.page

These rates are effective as of September 2022 and will remain in effect until further notice.

You are eligible to receive COBRA continuation coverage for 36 months. Please refer to the table below, which details the qualifying events for which you and/or your eligible dependents may be eligible to receive COBRA continuation coverage.

When is COBRA coverage Offered? (Qualifying Event)	***To whom is COBRA coverage offered?***	***For how long is COBRA coverage offered?***
• Reduction in hours of member's employment • Termination of member's employment (including unpaid leaves of absence) for any reason other than gross misconduct • Member's deferred retirement	• Employee • Spouse/Domestic Partner • Dependent children	36 months
When is COBRA coverage Offered? (Qualifying Event)	***To whom is COBRA coverage offered?***	***For how long is COBRA coverage offered?***
• Death of covered employee	• Spouse/Domestic Partner • Dependent children	36 months
• Divorce • Legal separation • Termination of domestic partnership	• Spouse/Domestic Partner • Dependent children	36 months
• Covered employee becomes eligible for Medicare	• Spouse/Domestic Partner • Dependent children	36 months
• Loss of eligible dependent child status	• Dependent child	36 months

Please do not send any premium payment with your MBF COBRA application. You will receive a bill from Healthplex, the MBF COBRA Billing Administrator.

For more detailed COBRA information, please visit the MBF Web site at nyc.gov/mbf.

If you have any questions, please contact MBF via email at the link below:
https://www1.nyc.gov/site/olr/webforms/send-message-management-benefits-fund.page

Sincerely,
The 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