



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

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

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.

	<i>Individual</i>	<i>Family</i>
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.

	<i>Individual</i>	<i>Family</i>
Dental & Vision Care	\$42.88	\$94.56

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

	<i>Individual</i>	<i>Family</i>
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.

<i>When is COBRA coverage Offered? (Qualifying Event)</i>	<i>To whom is COBRA coverage offered?</i>	<i>For how long is COBRA coverage offered?</i>
<ul style="list-style-type: none"> ● 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 	<ul style="list-style-type: none"> ● Employee ● Spouse/Domestic Partner ● Dependent children 	36 months
<i>When is COBRA coverage Offered? (Qualifying Event)</i>	<i>To whom is COBRA coverage offered?</i>	<i>For how long is COBRA coverage offered?</i>
<ul style="list-style-type: none"> ● Death of covered employee 	<ul style="list-style-type: none"> ● Spouse/Domestic Partner ● Dependent children 	36 months
<ul style="list-style-type: none"> ● Divorce ● Legal separation ● Termination of domestic partnership 	<ul style="list-style-type: none"> ● Spouse/Domestic Partner ● Dependent children 	36 months
<ul style="list-style-type: none"> ● Covered employee becomes eligible for Medicare 	<ul style="list-style-type: none"> ● Spouse/Domestic Partner ● Dependent children 	36 months
<ul style="list-style-type: none"> ● Loss of eligible dependent child status 	<ul style="list-style-type: none"> ● 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](https://www1.nyc.gov/mbf).

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Sincerely,
The City of New York
Management Benefits Fund



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Commissioner
Steven H. Banks
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General Counsel

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November 2021

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	<i>Individual</i>	<i>Family</i>
SMMP, Dental & Vision Care	\$44.20	\$106.00

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

	<i>Individual</i>	<i>Family</i>
Dental & Vision Care	\$32.11	\$73.44

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

	<i>Individual</i>	<i>Family</i>
SMMP only	\$12.09	\$32.56

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.

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Sincerely,
The City of New York
Management Benefits Fund



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)

Termination of Employment/Member
 Reduction of Work Schedule
 Divorce or Separation
 Date of Qualifying Event: / /

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					Status		
					Self	Spouse	Domestic Partner	Son	Daughter	Full-Time Student	Permanently Disabled	Covered by Other Group Insurance
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: / /