For MPE use only_____

Massachusetts Public Employees Fund
Vision and Dental Health Plans

Request for COBRA Continuation Coverage Retiree Enrollment Form

The Fund extends your benefits for one full calendar month after your retirement date (for example, if you retire on March 15th, your coverage will not end until April 30th).

- **The Fund cannot process this Request until our system terminates your coverage (in above example, April 30th).**
- **You will not receive confirmation of receipt of this Request.**
- **If a payment is received with this Request, it cannot be processed until we are able to enroll you in COBRA after our system terminates your coverage.**
- **You will not receive payment coupons until after we are able to enroll you in COBRA after our system terminates your coverage.**

Name of Fund Member: _____Subscriber ID: _____

Address:_____

City, State Zip:_____

Date of Retirement: _____ Phone Number:_____

I wish to enroll in the MPE Fund COBRA Continuation Coverage plan when my dental and vision benefits terminate due to my retirement. I understand I cannot enroll in this plan if I elect the Group Insurance Commission (GIC) retiree dental plan.

I am electing coverage for (circle one): Single Single Plus One Family

Names of Eligible Dependents (if electing 'single plus one' or family coverage):

_____

_____

_____

_____

I understand that I may also still receive a COBRA Election Form and Notice of Right to Continue Coverage (the "Notice") from the MPE Fund when my benefits end due to my retirement. By signing below I am confirming I have read and understand my COBRA rights as explained in the Notice. (Note: You may visit our website at www.mpefund.org to obtain the Notice).

Signature of Fund Member: _____ Date: _____