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 will process this Request:

1. **After you have already retired, and**
2. **No earlier than two weeks prior to the date your benefits will end due to claims systems requirements.**

Name of Fund Member: ________________________________Subscriber ID: ______________________

Address:____

City, State Zip:____

Date of Retirement: ____

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):

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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 *(required):* _______________________________ Date: ____________