

**COBRA Premium Payment Voucher
BHE/MTA Employee Health & Welfare Fund
Dental Care Program**

Plan No.: **93994-1-G**

Subscriber: _____ Identification No.: _____
(Last Name) (First & Middle Names)

Mailing Address: _____
(P.O. Box or Street Address) (City) (State) (Zip Code)

Coverage: Individual Family

Premium Amount: \$ _____ \$ _____

Coverage Period: Jan- Mar Apr - Jun Jul - Sep Oct - Dec

I certify that I am not enrolled in another Group Dental Care Program that provides similar benefits.

Please make check or money order payable to:
BHE/MTA Employee Health and Welfare Fund

**J.F.K. STATION, P.O. BOX 6249
BOSTON, MA 02114-0015**