# Health Benefits Program Application

Missouri Council of the Blind • moblind.org • (800) 342-5632

Plain PDF form. Print or write on the form to complete.

## Applicant Information

**First Name** _____

**Last Name** _____

**Email** _____

**Phone** _____

**Street Address** _____

**City / State / ZIP** _____

## Vision & Membership Status

**Vision Status** _____

**Membership Status** ☐ Affiliate Member ☐ Member-at-Large ☐ Not an MCB Member

**Affiliate Name** _____

## Illness or Accident Information

**Brief Description of Illness or Accident** _____

_____

_____

**Start Date of Illness/Accident** _____

**Expected End Date** _____

## Agreement & Signature

By typing your full name and date below, you certify that the above information is complete and accurate, and release MCB to verify your claim.

**Full Name (Electronic Signature)** _____

**Application Date** _____

Mail completed form to MCB St. Louis office.