### Adjunct Health Insurance Monthly Rates
**Effective 7/1/2021**

<table>
<thead>
<tr>
<th></th>
<th>Jul-21 Ind Monthly Cost</th>
<th>Jul-21 Family Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna EPO Basic</td>
<td>$419.13</td>
<td>$2,909.60</td>
</tr>
<tr>
<td>Aetna EPO w/Rider</td>
<td>$2,405.42</td>
<td>$8,527.48</td>
</tr>
<tr>
<td>CIGNA</td>
<td>$989.81</td>
<td>$3,859.62</td>
</tr>
<tr>
<td>CIGNA w/rider</td>
<td>$1,298.70</td>
<td>$4,794.25</td>
</tr>
<tr>
<td>Empire EPO</td>
<td>$1,028.87</td>
<td>$3,802.35</td>
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<tr>
<td>Empire EPO w/rider</td>
<td>$1,337.30</td>
<td>$4,558.49</td>
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<tr>
<td><em>Empire Blue Access Gated EPO</em></td>
<td>$303.30</td>
<td>$2,099.77</td>
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<tr>
<td><em>Empire Blue Access Gated EPO w/rider</em></td>
<td>$611.73</td>
<td>$2,855.91</td>
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<tr>
<td>GHI CBP Basic</td>
<td>$0.00</td>
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<tr>
<td>GHI CBP w/enhanced reimb. schedule rider</td>
<td>$4.14</td>
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<tr>
<td>GHI HMO</td>
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<td>GHI HMO w/rider</td>
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<tr>
<td>HIP HMO Basic</td>
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<td>$1,188.54</td>
</tr>
<tr>
<td>HIP HMO w/appliance, private duty nursing rider</td>
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<td>n/a</td>
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<tr>
<td>HIP Prime POS</td>
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<td>Hip Prime POS w/rider</td>
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<td>Vytra</td>
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<tr>
<td>Vytra w/rider</td>
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<td>$2,791.71</td>
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</tbody>
</table>

Please note - new rates are negotiated yearly.
New rates are usually effective from July 1 to June 30 of the following year.

*The Empire HMO plan has been terminated effective 1/1/2020
The Empire Blue Access Gated EPO plan has taken the place of the Empire HMO plan*
# Adjunct Health Insurance Verification Form

University Benefits Office  City University of New York  
555 West 57th Street - 11th Floor  
New York, NY 10019  
646-664-3401 Office, 646-664-3418 Facsimile, universitybenefitsadjuncts@cuny.edu

| Employee |  |
|----------|  |
| Last Name: _____________________ | First Name: _____________________ |
| Street Address: _____________________ |  |
| City: _____________________ State: ________ Zip Code: ________ |  |
| Marital Status: | □ Single □ Married □ Domestic Partner (circle one only) |
| CUNY Email Address: ____________ | Personal Email Address: ____________ |
| Day Phone Number: ____________ | Home Phone Number: ____________ |
| College #1: _____________________ Department: _____________________ | □ Teaching □ Non Teaching |
| College #2: _____________________ Department: _____________________ | □ Teaching □ Non Teaching |
| CUNY first Empl ID: ____________ | Semester: ____________ 20____ |

A certification must be submitted to the University Benefit Office every semester in order to maintain eligibility for Adjunct Health Insurance coverage. Below please check one item as it relates to your current status. After identifying your eligibility please sign and date.

☐ I do not have access to nor am I covered by other primary health insurance from any other source, including but not limited to other employment, my spouse/domestic partner's employment, Medicare (Part B) or the New York State Health Insurance Program (NYSHIP).

☐ I am now enrolled and covered by other primary health insurance from another source, including but not limited to other employment, my spouse/domestic partner's employment or the New York State Health Insurance Program (NYSHIP). My coverage is effective ________/______/______(mm/dd/yy).

Attestation: I hereby attest to the current eligibility status in the Adjunct Health Insurance Program as indicated above. I understand that it is my responsibility to contact my college Benefits Officer if, I will no longer be eligible for health insurance coverage and will be responsible for all medical expenses incurred. In the event that coverage terminates I may elect continuation of benefits at my own expense under COBRA. I understand that if I begin employment at a different campus, it is my responsibility to notify my current college Benefits Officer or my coverage may be terminated.

____________________________  ________________________
(Employee Signature)  (Date)
**Adjunct Health Insurance Certification Form**

Please see reverse side for instructions

University Benefits Office
City University of New York
555 West 57th Street - 11th Floor
New York, NY 10019

CUNYfirst Empl ID: ____________________________ Semester: __________________  20_______

Last Name: _______________________________ First Name: ________________________________

Street Address: ________________________________________

______________________________

City: ____________________________________    State: _________ Zip Code: ____________

Marital Status:  

☐ Single  ☐ Married/Domestic Partner

If you are married, you must provide information on your spouse, regardless of whether you elect family coverage.

CUNY Email Address: _______________________ Personal Email Address: ____________________________

Day Phone Number: __________________________ Home Phone Number: ______________________________

College # 1: _________________________________

Teaching ☐ Non Teaching ☐

Hours: ______________

Benefit Officer Initials:

College Department

College # 2: _________________________________

Teaching ☐ Non Teaching ☐

Hours: ______________

Benefit Officer Initials:

College Department

**Spouse/Domestic Partner Information**

Legal Relationship  ☐ Spouse  ☐ Domestic Partner

If you are married, you must provide information on your spouse, regardless of whether you elect family coverage.

Last Name: _______________________________ First Name: ________________________________

Spouse’s Employer: _____________________________________________________________

Spouse’s Health Insurance: ______________________________________________________

**Attestation:** I hereby attest that I have met the current eligibility requirements as outlined in the Adjunct Health Insurance Procedures. I further certify that I am not covered by nor eligible for other primary health insurance from any other source, including but not limited to other employment, my spouse/domestic partner’s employment or the New York State Health Insurance Program (NYSHIP). A certification must be submitted to the University every semester in order to maintain my eligibility for Adjunct Health Insurance coverage. Furthermore, I understand that it is my responsibility to contact my college Benefits Office if my hours fall below the required semester hours, as I will no longer be eligible for health insurance coverage and will be responsible for all healthcare costs incurred, unless I elect benefit continuation at my own expense under COBRA. I understand that I will make recurring payments through my bank account for health insurance coverage if applicable. I understand that if I go to a different school, it is my responsibility to notify my current college Benefits Officer or my coverage may be discontinued.

______________________________  ________________________________ ________________

(Employee Signature)  (Date)

**Benefits Officer Verification**

I hereby attest that the two-semester requirement has been met in accordance with the rules of the Collective Bargaining Agreement and that the hours and employment information is accurate for the semester indicated. The University Benefits Office at the current school, shall be apprised of all relevant changes to the employee’s schedule which will impact eligibility for health insurance.

______________________________  ________________________________ ________________

Benefits Officer  College 1  Date

______________________________  ________________________________ ________________

Benefits Officer  College 2  Date
The Adjunct Health Insurance Certification Form is required for processing your new health insurance coverage with the New York City Health Benefits Program. Please complete this form and submit to your college Benefits Officer, along with the Domestic Partner registration information or your Marriage/Civil Union Certificate, if applicable. (Please note: These documents are required for submission whether or not you intend to add your spouse/domestic partner to your coverage.)

1. Fill in your CUNYfirst Empl ID and Semester/Year for which you are applying for benefits.
2. Complete all fields within the "Employee" section with all appropriate information.
3. In the "Eligibility Qualification" section, your college Benefits Officer will certify the amount of teaching or non-teaching hours you work per week and initial in the space provided. PLEASE NOTE: If you are working at more than one campus to meet eligibility requirements, you must have the Benefits Officer from each college complete this section.
4. If you are married or have a domestic partner, the "Spouse/Domestic Partner" section must be completed whether or not you intend to add your spouse/domestic partner to your coverage. If your spouse/domestic partner is enrolled in a health plan other than your New York City Health Benefits Program coverage, you must indicate this information.
5. Please read the "Attestation" statement and sign your full name and date in the spaces provided.
6. The last section of this document is to be completed by the college Benefits Officer(s) who signs the "Eligibility Qualification" section. The last college Benefits Officer to sign the form, will forward this form and all other required enrollment paperwork to the University Benefits Officer.

Along with this form, please include your Domestic Partner registration information or Marriage/Civil Union Certificate if applicable. Please also submit your Employee Health Benefits Application, Adjunct Recurring Payment Election Form (if applicable), Adjunct PSC-CUNY Enrollment Form, HIPAA Certificate and all other supporting documentation (i.e., Age 26 Young Adult Paperwork, Birth Certificate(s) for child(ren), etc.) to the last college Benefits Officer who signs this form.
Please print all information clearly using a black or blue ballpoint pen.

Reason(s) for Submission (Check one or more boxes. Enter change Date, if appropriate)

A. New Enrollment
   - Reinstatement
   - Retirement
   - Disability Retirement
   - Accident Disability Retirement
   - Drop Optional Benefits

EMPLOYEES ONLY:
   - Add Optional Benefits
   - Waive Benefits

B. Change of:
   - Spouse/Domestic Partner: Add / Drop
   - Effective Date:
   - Dependent Child(ren): Add / Drop
   - Effective Date:
   - Change of Name - Former Name:

C. Transfer of Health Plan and/or Optional/Benefit based on:
   - Effective Date:
   - Retiree Once-in-A-Lifetime
   - Retirement Date:
   - City Start Date:

Employee/Retiree Signature: Date:

Retirement System (For Retiring Employees):
   - Years of Credited Service:
   - City:

List all eligible dependent children. Indicate if you are adding or dropping coverage by checking the appropriate box below.

Does spouse/domestic partner have Non-City group health plan? Is your spouse/domestic partner Medicare eligible:
   - Are you Medicare eligible: Yes / No
   - If YES, please attach a copy of your Medicare card to this application.

Name of current City Health Plan:

Parent's Last Name: Parent's First Name: Parent's M.I.: Social Security Number:

Date of Birth: Sex: Work - Telephone Number:
   - Mobile/Home - Telephone Number:
   - Email Address:

Enrollment Date:

Are you Medicare eligible: Yes / No

If YES, please attach a copy of his/her Medicare card to this application.

Health Plan Requested (Specify:
   - Optional Benefits
   - (Check "Yes" or "No" for optional benefits rider. If no box is checked, it will be presumed that you do not want optional benefits.) Yes / No

Employee/Retiree Signature: Date:

For completion by Payroll or Personnel Office Only

Certifying Signature: Date:

Telephone Number:

Agency Code: Title Code No.: Status: Appointment/Retirement Date: Effective Date of Coverage:

Full-Time / Permanent / Semi-Weekly / Semi-Monthly

Retirement System (For Retiring Employees):
   - Years of Credited Service:
   - City Start Date: Retirement Date:
   - City:

Pension Number:

Agency in which employed or retired from:

City:

Name of current City Health Plan:

Are you Medicare eligible: Yes / No

If YES, please attach a copy of his/her Medicare card to this application.

Family Information (Attach a second form if necessary. Dependents may be covered under two NYC Health Plans.

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

If YES, please attach a copy of his/her Medicare card if disabled dependent is Medicare eligible.

Transfer of Health Plan and/or Optional/Benefit Based on:

ATTACH COPY OF CARD

For Domestic Partner

Check one or more boxes. Enter change date, if appropriate.

City:

State:

Zip Code:

Country (if outside the U.S.):

Home Address:

Last Name: First Name: M.I.: Social Security Number:

Date of Birth:

Sex: Work - Telephone Number:
   - Mobile/Home - Telephone Number:
   - Email Address:

Agency in which employed or retired from:

Name of current City Health Plan:

Marital Status:
   - Single
   - Married
   - Widowed
   - Domestic Partnership

Does spouse/domestic partner have Non-City group health plan?

City Agency Name:

Is your spouse/domestic partner Medicare eligible: Yes / No

If YES, please attach a copy of his/her Medicare card to this application.

Employer's Agency Code:

Title Code No.: Status: Appointment/Retirement Date: Pay Period:
   - Effective Date of Coverage:
   - Semi-Monthly

Pension Number:

Employee/Retiree Signature: Date:

Address:

Enrollment Date:

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

If YES, please attach a copy of his/her Medicare card if disabled dependent is Medicare eligible.

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

If YES, please attach a copy of his/her Medicare card if disabled dependent is Medicare eligible.

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

If YES, please attach a copy of his/her Medicare card if disabled dependent is Medicare eligible.

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

If YES, please attach a copy of his/her Medicare card if disabled dependent is Medicare eligible.

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

If YES, please attach a copy of his/her Medicare card if disabled dependent is Medicare eligible.

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

If YES, please attach a copy of his/her Medicare card if disabled dependent is Medicare eligible.

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

If YES, please attach a copy of his/her Medicare card if disabled dependent is Medicare eligible.

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

If YES, please attach a copy of his/her Medicare card if disabled dependent is Medicare eligible.

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

If YES, please attach a copy of his/her Medicare card if disabled dependent is Medicare eligible.

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

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Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

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Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

Member's Last Name: Member's First Name: Date of Birth: Social Security Number:

Closing Statement:

I certify that the above information is correct and I authorize the City to deduct from my salary/pension the amount required, if any, through the City Health Benefits Program.

I understand that the City Program’s benefits will be coordinated with those available through Medicare or any other source.

Furthermore, I agree that my periodic health plan deductions, if any, will be made on a pre-tax basis pursuant to the Internal Revenue Code 125. I understand that I have an option to decline this benefit, by obtaining a Medical Spending Conversion Form, both of which are obtainable at my payroll office. (Section 125 does not apply to retirees.)

If I have checked the Waive Benefits Box in Section A, I am choosing not to participate in the City Health Benefits Program at this time.

Employee/Retiree Signature: Date:

Health Benefits Program

40 Rector Street - 3rd Fl.
New York, NY 10006
Tel: (212) 306-7756
Fax: (212) 306-7151

Health Benefits Program

For Domestic Partner

Changes - Return Form to:

Employees Return Form to:

Retirees Return Form to:

New York, NY 10006
Attn: Domestic Partner Unit

New York, NY 10006
Instructions for Completing a Health Benefits Application/Change Form

Section A: If you are a NEW retiree, you should only select from the following: Retirement, Disability Retirement, Accident Disability Retirement or Waive Benefits.

If you are already covered as a retiree, you should only select from the following: Drop/Add Optional Benefits, Waive Benefits (if you wish to cancel your City coverage) and Reinstatement (if you are requesting to reinstate your City coverage after having previously waived coverage).

Section B: Check Spouse/Domestic Partner Information (Add/Drop) if you are adding or dropping a spouse/domestic partner.

If your spouse/domestic partner is deceased, you must attach a copy of the death certificate.

If you are dropping your spouse as a result of a divorce, you must attach a copy of the divorce decree.

If you are adding a spouse, domestic partner or dependent child(ren) please refer to the SPD or the Dependent Eligibility Required Documentation instructions on our Web site, at nyc.gov/hbp, for a list of all dependent eligibility documentation requirements for health benefits coverage for dependents.

Check Dependent Child(ren) Add or Drop if you are adding or dropping a dependent child.

If you are adding a dependent child, you must attach a copy of either the birth certificate, or documents proving guardianship or adoption.

If changing your name, please indicate your former name and provide documentation of name change.

Section C: Check Transfer Period if the change you are requesting (such as Adding Optional Benefits or Changing Plans) is being made during a Transfer Period.

Check Permanent Move Into/Out of Health Plan Area if you are requesting to change plans as a result of either moving out of the service area of your current plan, or if you are moving into the service area of another plan.

Check Retiree Once in a Lifetime if you are requesting to change plans or add optional benefits anytime other than a transfer period.

Section D: If you are enrolled in Medicare Parts A & B, you must attach a photocopy of your Medicare card.

Section E: If you are married or have a domestic partner, this section must be completed only if you are covering your spouse/domestic partner.

If your spouse/domestic partner is enrolled in health plan other than your City coverage or Medicare, you must indicate so.

If your spouse/domestic partner is enrolled in Medicare Parts A & B, you must attach a photocopy of his/her Medicare card.

Section F: List ALL eligible dependent children to be covered. If a dependent child is permanently disabled, and on Medicare, you must attach a photocopy of his/her Medicare card. (CUNY ADJUNCT EMPLOYEES: City rates apply for Individual coverage ONLY. Contact your Benefits Office for information about additional cost for Family coverage.)

Section G: Write the complete name of your current health plan or the plan you are selecting (see back of sheet). If you do not make an optional rider selection, you will be given basic coverage only.

Section H: This section is for employees only who wish to participate in the Buy-Out Waiver Program. Remember to date your form. Retirees, Line of Duty Survivors and CUNY Adjunct employees are not eligible for the Buy-Out Waiver Program.

Section I: Your signature is required in this section to enroll or effect the changes requested on this Application/Change Form.

Section J: If you are a NEW retiree (even if you are waiving City coverage), your payroll/personnel office must complete this section.

See top, right-hand corner of reverse side for instructions on submitting this Application/Change Form. Retain a copy for your records.
Health Plans Available to
Employees, Non-Medicare Retirees and their Dependents

Aetna EPO
Cigna HealthCare
DC 37 Med-Team (DC 37 members only)
Empire EPO
Empire HMO
GHI-CBP/Empire BlueCross BlueShield
GHI HMO
HIP Prime HMO
HIP Prime POS
MetroPlus Gold
Vytra Health Plans

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

Health Plans Available to
Medicare-Eligible Retirees and their Dependents

Aetna Medicare PPO ESA Plan*
AvMed Medicare HMO* (Florida only)
Cigna HealthSpring Preferred with Rx (HMO)* (Arizona only)
DC 37 Med-Team Senior Plan (DC 37 Members Only)
Elderplan*
Empire Medicare Related Coverage
Empire MediBlue HMO*
GHI/Empire BlueCross BlueShield Senior Care
GHI HMO Medicare Senior Supplement
HIP VIP Premier (HMO) Medicare Plan*
Humana Gold Plus (certain counties in Florida)*
UnitedHealthcare Group Medicare Advantage Plan*

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

* Medicare eligible retirees who wish to enroll in these plans must enroll DIRECTLY with the health plan. Please verify with the health plan of your choice whether or not you reside in its service area. Do not use this form for enrollment in these plans.
**Adjunct Enrollment Form**

**PSC-CUNY Welfare Fund**  
61 Broadway, 15th Floor  
New York, NY 10006  
Office: 212-354-5230  Fax: 212-354-5363  
Website: www.psccunywf.org

A copy of your NYC Health Benefits Application is required and/or WF Domestic Partner form if Applicable.

Dependent information will be obtained from your NYC Health Application unless you indicate otherwise.

<table>
<thead>
<tr>
<th>Member</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NYSUT ID: ___________________________</td>
<td>NYS ID (State Colleges): ___________________________</td>
</tr>
<tr>
<td>Social Security: ____________________</td>
<td>Date of Birth: ___ / ___ / ___</td>
</tr>
<tr>
<td>First Name: _________________________</td>
<td>Last Name: _________________________</td>
</tr>
<tr>
<td>Address: ___________________________</td>
<td></td>
</tr>
<tr>
<td>City: _____________________________</td>
<td>State: ______ Zipcode: ________</td>
</tr>
<tr>
<td>Marital Status: ☐ S ☐ M ☐ DP</td>
<td>Gender: ☐ F ☐ M</td>
</tr>
<tr>
<td>Primary Telephone: (___)</td>
<td>Primary Email: ___________________________</td>
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For more information visit: www.psccunywf.org

<table>
<thead>
<tr>
<th>Dental</th>
<th>Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guardian</td>
<td>Basic Rider Waived Stipend</td>
</tr>
<tr>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>DeltaCare USA</td>
<td>☐ ☐ ☐ ☐</td>
</tr>
</tbody>
</table>

*Delta will assign you a Dentist. To change it, call Delta or go Online.

I hereby certify that all of my personal information presented here is true and accurate.

Signature ___________________________  
Date ___________________________

I hereby certify to the best of my knowledge that the information presented here is accurate, complete and sufficient to verify eligibility for benefits under the PSC-CUNY Welfare Fund.

Effective Date of Coverage: ___ / ___ / ___  
Effective Date of Hire: ___ / ___ / ___  
Earliest CUNY Hire Date: ___ / ___ / ___

HR Signature - College 1  
Print Name ___________________________  
Date ___________________________

HR Signature - College 2  
Print Name ___________________________  
Date ___________________________

PSC-CUNY Welfare Fund Use Only] [Alpha]  
Date Received ___________________________  
Authorization ___________________________  
Initials ___________________________  
Date ___________________________

Revised 2/2017 RN
**Adjunct Family Enrollment Supplement**

**PSC-CUNY Welfare Fund**

61 Broadway, 15th Floor  
New York, NY 10006  
Phone (212) 354-5230  
Fax (212) 354-5363

A copy of your NYC Health Benefits Enrollment Form must be attached.  
A copy of your PSC-CUNY Welfare Fund Enrollment Form must be attached.  
Enrollment in Family Coverage through NYC Health Benefits is Required

<table>
<thead>
<tr>
<th>Enrollee</th>
<th>NY State / NY City ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Social Security Number</td>
<td>- -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Male</th>
<th>Female</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse / Domestic Partner</td>
<td></td>
<td></td>
<td>- -</td>
<td>/ /</td>
</tr>
<tr>
<td>Dependent Child</td>
<td></td>
<td></td>
<td>- -</td>
<td>/ /</td>
</tr>
<tr>
<td>Dependent Child</td>
<td></td>
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<td>Dependent Child</td>
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<td>Dependent Child</td>
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<td>/ /</td>
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<tr>
<td>Dependent Child</td>
<td></td>
<td></td>
<td>- -</td>
<td>/ /</td>
</tr>
</tbody>
</table>

I hereby certify that all information I have provided on this Enrollment Form is true and accurate.  
I further agree to pay the posted premium for family coverage to the PSC-CUNY Welfare Fund  
Effective Rate 7/1/2016 $190.75 / mo.

Member Signature | Date |
|------------------|------|

[College HR Office Use Only]

The individual named herein is eligible for family coverage under the PSC-CUNY Welfare Fund and  
All required documents have been presented to authorize coverage of individuals listed herein.

Signature | Name | Title / Campus | Date Signed |
|-----------|------|----------------|-------------|

[ PSC-CUNY Welfare Fund Use Only]

Status | Authorization
CUNYfirst Empl ID: ___________________________

Full Name: __________________________________ College 1: ___________________________
(Your Name as it appears on Bank Statements)
Personal Email: ______________________________ College 2: ___________________________

Banking Institution: ___________________________________ Routing Number: ___________________

☐ Checking Account (Attach Voided Check)  ☐ Savings Account (Bank Signature Required)

Account Number: _________________________________

Amount to be deducted monthly: __________________________

For savings accounts, and checking accounts without a voided check:
As a representative of the above named financial institution, I certify that this institution is ACH capable and agree that payments can be remitted from the account shown above.

__________________________________________  __________________________________________
(Bank Rep's Printed Name)  (Bank Rep's Signature)  (Bank Rep's Telephone Number)

Employee/Joint Account Holders Certification: I certify that I have read and understand this form. By signing this form, I authorize my health insurance costs to be deducted from the account listed on this form. The joint account holder(s) for the account listed, if any, must sign on the corresponding line(s) for additional account holder(s).

Employee Signature: ________________________________  Date: ______________

Joint Account Holder: ________________________________  Date: ______________

Joint Account Holder: ________________________________  Date: ______________

By signing below, I certify that I permit the City University of New York to electronically withdraw funds from the above mentioned account to cover the expenses of my health insurance premiums, if any, based on the Adjunct Health Insurance Rate Sheet. I fully understand that the funds will be deducted from my account on a monthly basis on the first business day of the month preceding the period of coverage for which I am paying or the next possible administratively feasible date. I understand and agree that I am responsible for any fees associated with transactions due to insufficient funds in my account. I authorize the modification of deductions from my account due to future changes in expenses, including but not limited to premium rate and administrative fee changes, changes to my insurance made by me during the open enrollment period, and family status changes, in order to keep my health insurance current.

I, ________________________________, agree to the terms above, and I am fully aware that failure to remit payment according to these terms may result in the termination of my health insurance coverage.

________________________________________________________  ______________
(Employee Signature)  (Date)
Adjunct Recurring Payment Election Form Instructions

This form should be completed by eligible Adjunct faculty members who are enrolling in a health plan for which premiums are required to be paid. This form, along with all the other required documents and forms to enroll in the New York City Health Benefits Program and the PSC/CUNY Welfare Fund Supplemental Benefits must be completed and submitted to your college Benefits Officer. If you are electing to have funds deducted from your checking account, you will need to include a voided check with this form. If you are electing to have funds deducted from your savings account, or a checking account for which you do not have a voided check, you are required to obtain a bank representative's signature in the space provided on this form. Please carefully follow the instructions below to complete this form.

1. Enter your CUNYfirst Empl ID and the Semester/Year for which you are applying for benefits in the spaces provided at the top of the form.
2. Enter your full name as it appears on your bank statements in the space provided for "Full Name".
3. Enter the name of the college(s) at which you are employed in the space(s) provided.
4. Enter your personal email address in the space provided.
5. Enter the name of your bank in the space provided for "Banking Institution".
6. Enter the nine digit Routing Number for your bank as it appears at the bottom of your personal checks or savings account deposit slips.
7. Fill in the radio button that corresponds with the account from which you wish to have your payments deducted.
8. Enter the Account Number from which you wish to have your monthly premium remittance withdrawn in the space labeled "Account Number".
9. Enter premium amount to be paid monthly in the space provided. Please refer to the rate sheet on the UBO website. http://www.cuny.edu/benefits
10. If the account listed is a joint account, you and the joint account holder(s) must complete the Employee/Joint Account Holders Certification section by signing and dating the form in the spaces provided.
11. Carefully read the terms of automatic recurring payments.
12. Print your name in the space provided.
13. Sign and date the form at the bottom of the document in the space provided.