Adjunct Health Insurance Verification Form

Office of Human Resources Management
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-EMP 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)