



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: Fall 2023

Employee	
Last Name: _____	First Name: _____
Street Address: _____	
City: _____	State: _____ Zip Code: _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> 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: _____

Eligibility Qualifications	
College # 1: _____ College Department	<input type="checkbox"/> Teaching <input type="checkbox"/> Non Teaching Hours Benefit Officer Initials
College # 2: _____ College Department	<input type="checkbox"/> Teaching <input type="checkbox"/> Non Teaching Hours Benefit Officer Initials

Spouse/Domestic Partner Information	
Legal Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> 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.		
_____	CCNY	_____
Benefits Officer	College 1	Date
_____	_____	_____
Benefits Officer	College 2	Date

Adjunct Health Insurance Certification Form Instructions

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.