Health Benefits Application

Please print all information clearly using a black or blue ballpoint pen.

Health Benefits Program
40 Rector Street - 3rd Floor
New York, NY 10006
(212) 513-0470
TTY/TDD: (212) 306-7753
www.nyc.gov/olr

Applicant MUST check one:
- ❑ EMPLOYEE
- ❑ RETIREE
- ❑ LINE OF DUTY SURVIVOR

REASON(S) FOR SUBMISSION (check one or more boxes:enter change date if appropriate)

A.
- ☒ New Enrollment
- ❑ Reinstatment
- ❑ Retirement
- ❑ Disability Retirement
- ❑ Accident Disability Retirement
- ❑ Drop Optional Benefits
- ❑ Other:_____
- ❑ Add Optional Benefits
- ❑ Cancel Benefits (CHECK ONE)
  - ❑ Waive Benefits
  - ❑ Buy-Out Waiver (EMPLOYEES ONLY COMPLETE SECTIONS D, E, F & I ONLY)

B. **Transfer of Health Plan and/or Optional/Benefit Based on:**
- ❑ Transfer Period
- ❑ Permanent Move Into/Out of Health Plan Area
  Effective Date: _____/_____/_____
- ❑ Retiree Once-in-A-Lifetime
- ❑ Other:_____

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

D. EMPLOYEE/RETIREE INFORMATION

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

Home Address:	Apt. No:

City:	State:	Zip Code:	Country (if outside the U.S.):

Date of Birth:	Sex:	Home - Telephone Number:	Work - Telephone Number:	Mobile - Telephone Number:
/ /	❑M ❑F	( ) -	( ) -	( ) -

Marital Status:	Date of Event (MM/DD/YY)	Agency in which employed or retired from:	Union or Welfare Fund
❑Single ❑Married ❑Divorced ❑Widowed ❑Domestic Partnership	/ /		

Name of current City Health Plan:	Medicare Claim Number:	❑If Medicate Part A EffectiveDate: / /	❑If Medicate Part B EffectiveDate: / /	ATTACH COPY OF CARD

THIS SECTION RETIREES ONLY

Retirement System:	Years Credited Service:	City Start Date:	Retirement Date:	Pension Number:
		/ /	/ /	

E. SPOUSE/DOMESTIC PARTNER INFORMATION

Last Name:	First Name:	M.I.:	Social Security Number:	Date of Birth:
			- -	/ /

Is spouse/domestic partner: ❑Employed ❑Retired ❑Not Employed ❑City Agency Name:_____ ❑Non-City Related	Is spouse/domestic partner to be covered by employee/retiree's Health Plan? **(Double City coverage is not permitted)** ❑Yes ❑No

Does spouse/domestic partner have Non-City group health plan? ❑Yes ❑No	Medicare Claim Number:	❑If Medicate Part A EffectiveDate: / /	❑If Medicate Part B EffectiveDate: / /	ATTACH COPY OF CARD

F. FAMILY INFORMATION (Attach a second form if necessary; dependent may not be covered under two NYC Health Plans.)

List all eligible dependents to be covered by your Health Plan.
(CUNY ADJUNCT EMPLOYEES: City rates apply for Individual coverage ONLY. Contact your Benefits Office for information about additional cost for Family coverage.)

	Last Name:	First Name:	Date of Birth:	Social Security Number:	Sex:	Check if Applicable: FULL-TIME STUDENT	PERMANENTLY DISABLED	DROP COVERAGE
Spouse/Domestic Partner			/ /	- -		❑	❑	❑
Dependent			/ /	- -		❑	❑	❑
Dependent			/ /	- -		❑	❑	❑
Dependent			/ /	- -		❑	❑	❑
Dependent			/ /	- -		❑	❑	❑

G. HEALTH PLAN REQUESTED (Please print clearly)

HEALTH PLAN NAME IN FULL: _____

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

H. TO PARTICIPATE IN THE HEALTH BENEFITS PROGRAM - PLEASE SIGN AND DATE BELOW (Participant must sign either Section H or I)

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: / /

I. TO PARTICIPATE IN THE HEALTH BENEFITS BUY-OUT WAIVER PROGRAM - SIGN AND DATE BELOW (Participant must sign either Section H or I)

I wish to partipcate in the Health Benefits Buy-Out Waiver Program. I have read the Medical Spending Conversion Health Benefits Buy-Out Waiver Program brochure and completed a Medical Spending Conversion Form and I attest that I meet the qualifications for this program. (Retirees, Line of Duty Survivors and CUNY Adjunct employees are not eligible.)

Employee Signature: Date: / /

J. FOR COMPLETION BY PAYROLL OR PERSONNEL OFFICE ONLY

I certify that the above employee/retiree is eligible for the New York City Health Benefits Program (HBP) and that dependent documentation has been verified in accordance with HBP procedures.

I certify that the above employee is eligible for the Health Benefits Buy-Out Waiver Program and I have reviewed and processed the Medical Spending Conversion Form and I attest that the employee meets the qualifications for this Program.

✍ Certifying Signature:	Date:	Telephone Number:
Kim M. Ferguson	/ /	(212) 650 -7963

Agency Code:	Title Code No.:	Status:	Appointment/Retirement Date: (MM/DD/YYYY)	Pay Period:	Effective Date of coverage: (MM/DD/YYYY)
		❑ Full-Time ❑ Civil Servant ❑ Part-Time ❑ Provisional	/ /	❑ Weekly ❑ Monthly ☒ Bi-Weekly ❑ Semi-Monthly	/ /

Instructions for Completing a Health Benefits Application for Retirees

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Section A: If you are a NEW retiree, you should only select from the following: Retirement, Disability Retirement, Accident Disability Retirement, Deferred 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 Transfer Period if the change you are requesting is being made during a Transfer Period (such as Adding Optional Benefits or Changing Plans). 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 C: Check Spouse 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 a 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, you must attach a copy of the marriage certificate or submit domestic partner documentation if adding a domestic partner. Check Dependent (Children) (Add/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.

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 whether or not 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** dependents to be covered. You must indicate yes/no if a dependent is a full-time student. If a dependent 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 is the only section in which you are to sign the form. Remember to date your form.

Section I: **Retirees, Line of Duty Survivors and CUNY Adjunct employees are not eligible for the** Buy-Out Wavier Program.

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

Retirees: ***Return this application to:*** City of New York
Health Benefits Program
40 Rector Street – 3rd Floor
New York, New York 10006

Health Plans Available to
Employees, Non-Medicare Retirees and their Dependents

Aetna HMO
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 Health Plan (HHC Employees and Non-Medicare Retirees only)
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 Golden Medicare 10
Avmed Medicare Plan
BlueCross BlueShield of Florida Health Options, Inc.*
Cigna HealthCare for Seniors* (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 Medicare Plan*
Humana Gold Plus (certain counties in Florida)*
SecureHorizons by UnitedHealthCare *

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 Basic Plan and Optional Rider Monthly Rate Sheet

These rates are in effect as of July 2014
(All rates are subject to change)

		Monthly Individual Coverage	Monthly Family Coverage
Aetna HMO*	Basic Plan	$143.40	$1,607.00
Optional Rider	Prescription Drugs	$136.40	N/A
	Total	**$279.80**	**$1,936.80**
Cigna Healthcare*	Basic Plan	$524.34	$2,285.48
Optional Rider	Prescription Drugs	$207.01	N/A
	Total	**$731.35**	**$2,905.25**
Empire EPO**	Basic Plan	$439.44	$1,978.13
Optional Rider	Prescription Drugs	$126.61	N/A
	Total	**$566.05**	**$2,288.51**
Empire HMO**	Basic Plan	$200.14	$1,458.15
Optional Rider	Prescription Drugs	$126.61	N/A
	Total	**$326.75**	**$1,768.53**
GHI-CBP/EBCBS	Basic Plan	$0.00	$849.85
	Enhanced Reimbursement Schedule	$6.88	$17.43
	Total	**$6.88**	**$867.28**
GHI HMO*	Basic Plan	$95.04	$1,150.70
Optional Rider	Prescription Drugs	$164.93	N/A
	Total	**$259.97**	**$1,571.23**
HIP Prime HMO	Basic Plan	$0.00	$849.85
	Appliance & Private Duty Nursing	Not Currently Available	Not Currently Available
	Total	**$0.00**	**$849.85**
HIP Prime POS*	Basic Plan	$676.48	$2,507.45
Optional Rider	Prescription Drugs	$464.61	N/A
	Total	**$1,141.09**	**$3,639.28**
Vytra**	Basic Plan	$58.20	$1,111.10
Optional Rider	Prescription Drugs	$154.34	N/A
	Total	**$212.54**	**$1,512.49**

NOTE:* Individual prescription drug coverage is provided by the PSC-CUNY Welfare Fund for all healthplans. Currently, family coverage is not available. However, you may elect the optional prescription rider for Aetna HMO, Cigna Healthcare, GHI HMO or HIP Prime POS and have your prescription coverage provided by the healthplan. If you elect the optional prescription rider for any of these plans, you may be eligible to receive a stipend from the PSC-CUNY Welfare Fund.

** If you select the optional prescription rider for these plans, you will pay the full total amount (basic plus optional rider). Your prescription drug coverage will be provided by the healthplan, not through the PSC-CUNY Welfare Fund.

The following Point-of-Service (POS), Exclusive Provider Organization (EPO), and Participating Provider Organization/Indemnity (PPO) plans are offered by the Health Benefits Program

Health Plan	Phone Number	Web Address
Empire EPO	(800) 767-8672	www.empireblue.com/nyc
GHI-CBP/Empire BlueCross BlueShield		
Group Health Incorporated:	(212) 501-4444	www.emblemhealth.com
Empire BlueCross BlueShield:	(800) 433-9592	www.empireblue.com/nyc
HIP Prime POS	(800) 447-6929	www.emblemhealh.com

The following Health Maintenance Organizations (HMO) are offered by the Health Benefits Program

Health Plan	Phone Number	Web Address
Aetna HMO	(800) 445-8742	www.aetna.com
CIGNA HealthCare	(800) 244-6224	www.cigna.com
Empire HMO	(800) 767-8672	www.empireblue.com/nyc
GHI HMO	(877) 244-4466	www.emblemhealth.com
HIP PRIME HMO	(800) 447-6929	www.emblemhealth.com
Vytra Health Plans	(800) 448-2527	www.vytra.com

The following Point-of-Service (POS), Exclusive Provider Organization (EPO), and Participating Provider Organization/Indemnity (PPO) plans are offered by the Health Benefits Program

Health Plan	Phone Number	Web Address
Empire EPO	(800) 767-8672	www.empireblue.com/nyc
GHI-CBP/Empire BlueCross BlueShield		
Group Health Incorporated:	(212) 501-4444	www.emblemhealth.com
Empire BlueCross BlueShield:	(800) 433-9592	www.empireblue.com/nyc
HIP Prime POS	(800) 447-6929	www.emblemhealh.com

The following Health Maintenance Organizations (HMO) are offered by the Health Benefits Program

Health Plan	Phone Number	Web Address
Aetna HMO	(800) 445-8742	www.aetna.com
CIGNA HealthCare	(800) 244-6224	www.cigna.com
Empire HMO	(800) 767-8672	www.empireblue.com/nyc
GHI HMO	(877) 244-4466	www.emblemhealth.com
HIP PRIME HMO	(800) 447-6929	www.emblemhealth.com
Vytra Health Plans	(800) 448-2527	www.vytra.com

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_____

Employee

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: _____

Eligibility Qualifications

College # 1: _____ ☐ Teaching ☐ Non Teaching _____ _____

College Department Hours Benefit Officer Initials

College # 2: _____ ☐ Teaching ☐ Non Teaching _____ _____

College Department Hours Benefit Officer Initials

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

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.

Adjunct Enrollment Form

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.

All Paperwork must be returned to your Benefits Officer. Do Not Submit Directly to the Welfare Fund.

Enrollee

NYS Payroll "N" Number/ NYC Reference # _____

Last Name _____ **First Name** _____

Social Security Number ___ - ___ - ____ **Job Title** _____

Home Address _____

City _____ **State** _____ **Zip Code** _____

Primary Contact # ( ) _____ **Primary Email** _____

Date of Birth _____ **Gender** M **Marital Status** _____ **Domestic Partner** ☐

CUNY Campus(es)

_____

_____

Health Insurance Basic ☐ Rider ☐

_____

Welfare Fund Dental Option

Guardian ☐

DeltaCare USA ***(Attach DeltaCare Form)*** ☐

Date of Hire _____

Earliest CUNY Hire Date _____

Previous College (if applicable) _____

I hereby certify that all information I have provided on this Enrollment Form is true and accurate.

Member Signature _____ **Date** / /

[College HR Office Use Only]

Check here if you are including hours from another college ☐

The individual named herein is eligible for coverage under the PSC-CUNY Welfare Fund effective / /
Date

Signature	Name	Title/ Campus	Date Signed
			/ /
Signature	Name	Title/ Campus	Date Signed
			/ /

[PSC-CUNY Welfare Fund Use Only]

Status _____ Authorization _____

Adjunct Recurring Payment Election 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: _____

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.