Health Benefits Program
Application/Change Form

www.nyc.gov/olr

Employees Return Form to:	Retirees (212) 513-0470 Return Form to:	For Domestic Partner Changes - Return Form to:
Your Agency's Payroll or Personnel Office	**Health Benefits Program** 40 Rector Street - 3rd Fl. New York, NY 10006 FAX: (212) 306-7756	**Health Benefits Program** 40 Rector Street - 3rd Fl. New York, NY 10006 Attn: Domestic Partner Unit

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

Applicant MUST check one: ☐ EMPLOYEE ☐ RETIREE ☐ RETURN TO RETIREMENT (Check this box if you were previously retired) ☐ LINE OF DUTY SURVIVOR

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*
- ☐ Add Optional Benefits*
- ☐ Waive Benefits*

EMPLOYEES ONLY:
- ☐ Buy-Out Waiver Program
  COMPLETE SECTIONS D, E, F & H

*Please indicate Effective Date: _____/_____/_____

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:
- ☐ Transfer Period
- ☐ Move Into/Out of Health Plan Area
  Effective Date: _____/_____/_____
- ☐ Retiree Once-in-A-Lifetime
  Effective Date: _____/_____/_____

D. EMPLOYEE/RETIREE INFORMATION

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

Home Address:	Apt.:

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

Date of Birth:	Sex:	Work - Telephone Number:	Mobile\Home - Telephone Number:	E-mail Address:
/ /	☐M ☐F	( ) -	( ) -	

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

Name of current City Health Plan:	Are you Medicare eligible: ☐Yes ☐No If YES, please attach a copy of your Medicare card to this application.	ATTACH COPY OF CARD

E. SPOUSE/DOMESTIC PARTNER - ONLY COMPLETE IF YOUR SPOUSE/DOMESTIC PARTNER IS TO BE COVERED. IF NOT, LEAVE BLANK.

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

Sex: ☐M ☐F

Is spouse/domestic partner: ☐Employed (**Double City coverage is not permitted**) ☐Retired (**Double City coverage is not permitted**) ☐Not Employed ☐City Agency Name:_____ ☐Non-City Related

Does spouse/domestic partner have Non-City group health plan? ☐Yes ☐No	Is your spouse/domestic partner Medicare eligible: ☐Yes ☐No If YES, please attach a copy of his/her Medicare card to this application.	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 dependent children. Indicate if you are adding or dropping coverage by checking the appropriate box below.
(CUNY ADJUNCT EMPLOYEES: CITY RATES APPLY FOR INDIVIDUAL COVERAGE ***ONLY***. CONTACT YOUR BENEFITS OFFICE FOR INFORMATION ABOUT ADDITIONAL COST FOR FAMILY COVERAGE.)

*Attach a copy of Medicare card if disabled dependent is Medicare eligible.

Dependent's Last Name:	Dependent's First Name:	Date of Birth:	Social Security Number:	Sex: M/F	ADD COVERAGE	DROP COVERAGE	PERMANENTLY DISABLED*
		/ /	- -		☐	☐	☐
		/ /	- -		☐	☐	☐
		/ /	- -		☐	☐	☐
		/ /	- -		☐	☐	☐
		/ /	- -		☐	☐	☐

G. HEALTH PLAN REQUESTED (Please print clearly)

FULL NAME OF HEALTH PLAN SELECTED: _____

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. EMPLOYEES ONLY (RETIREES ARE INELIGIBLE FOR THE HEALTH BENEFITS BUY-OUT WAIVER PROGRAM)

I wish to participate 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:

I. TO PARTICIPATE IN THE HEALTH BENEFITS PROGRAM OR REQUEST CHANGES TO HEALTH COVERAGE

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:

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 Buy-Out Spending Form and I attest that the employee meets the qualifications for this Program.

Agency Code:	Title Code No.:	Status: ☐Full-Time ☐Part-Time ☐Permanent ☐Provisional	Appointment/Retirement Date:	Pay Period: ☐Weekly ☐Monthly ☐Bi-Weekly ☐Semi-Monthly	Effective Date of Coverage:
			/ /		/ /

Retirement System (For Retiring Employees):	Years of Credited Service:	City Start Date:	Retirement Date:	Pension Number:
		/ /	/ /	

Certifying Signature:	Date:	Telephone Number:
	/ /	( ) -

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 Wavier 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.

Change of Status

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

Required

Include supporting documentation: marriage certificate, birth certificate and/or NYC Health Benefits application.

If adding Domestic Partner include a WF Domestic Partner Enrollment Form

Member

Enter Member Name, SSN as currently reported to the PSC CUNY Welfare Fund.

Social Security: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Type of Change

☐ Name: _____

☐ Address: _____

☐ Health Plan: _____ ☐ Basic ☐ Rider ☐ Waived ☐ Stipend

☐ Marital Status: ☐ Domestic Partner ☐ Marriage ☐ Divorce ☐ Death of Spouse Date of Event ____/____/____

☐ Email: (H) _____ ☐ Email: (W) _____

☐ Tele: (H) _____ ☐ Tele: (W) _____

Only for Annual Dental Plan Changes Effective January 1.

☐ DeltaCare USA HMO to Guardian PPO ☐ Guardian PPO to DeltaCare USA HMO

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

☐ Other: _____

Change in Number of Dependents

⊕ Add Dependents

Name	Relationship	SSN	DOB	Reason

⊖ Drop Dependents

☐ Drop RX

☐ Drop Dental, Vison and Hearing

☐ Drop All Benefits

Name	Relationship	Date of Event	Reason

College

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.

Benefits Officer _____ Date _____

[PSC-CUNY Welfare Fund Use Only] [Alpha]

Date Received Authorization Initials Date