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:
	/ /		

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:
			- -	/ /

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.

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

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 ❑ Bi-Weekly ❑ Monthly ❑ 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: ( ) -

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** ____ **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 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 Beneftis Enrollment Form must be attached.

A copy of your PSCCUNY Welfare Fund Enrollment Form must be attached.

Enrollment in Family Coverage through NYC Health Benefits is Required

Enrollee

NY State / NY City ID # _____

Last Name _____ **First Name** _____

Social Security Number - -

	Name	Male	Female	Social Security Number	Date of Birth
Spouse / Domestic Partner		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /

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 10/1/2014 $202.00 / 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 _____

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 Fax, universitybenefitsadjuncts@cuny.edu

EMPLOYEE:

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner

CUNY Email Address: _____ Personal E-mail 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 you eligibility please sign and date.

☐ I do not have access to, nor am I covered by, other primary health insurance from any source including by 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 of 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's Signature) (Date)

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.

Adjunct Health Insurance Monthly Rates Effective 1/1/2020	Jan-20 Ind Monthly Cost	Jan-20 Family Monthly Cost
Aetna EPO Basic	$279.00	$2,354.49
Aetna EPO w/Rider	$1,934.32	$7,036.30
CIGNA	$819.98	$3,315.33
CIGNA w/rider	$1,118.88	$4,208.35
Empire EPO	$860.21	$3,281.19
Empire EPO w/rider	$1,121.60	$3,922.00
*Empire Blue Access Gated EPO	$342.19	$2,094.84
*Empire Blue Access Gated EPO w/rider	$603.58	$2,735.65
GHI CBP Basic	$0.00	$1,165.17
GHI CBP w/enhanced reimb. schedule rider	$4.61	$1,176.83
GHI HMO	$200.36	$1,678.46
GHI HMO w/rider	$568.60	$2,617.42
HIP HMO Basic	$0.00	$1,092.43
HIP HMO w/appliance, private duty nursing rider	$0.00	n/a
HIP Prime POS	$1,067.00	$3,706.59
Hip Prime POS w/rider	$1,352.35	$4,405.71
METROPLUS	$0.00	$1,092.43
Vytra	$156.00	$1,641.72
Vytra w/rider	$474.59	$2,470.55

Please note - new rates are negotiated yearly.
New rates are usually effective from July to June 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