BMCC
Human Resources

Borough of Manhattan Community College
The City University of New York
www.bmcc.cuny.edu

199 Chambers Street
New York, NY 10007-1097
tel. 212-220-8300
fax 212-220-2364

Dear New Employee

Welcome to BMCC. Attached are a variety of documents concerning your appointment to the college that you need to be aware of or must complete. Please read these materials carefully and provide all of the requested information as quickly as possible.

The offer of this employment is conditional upon satisfactory completion of all verifications, including but not limited to confirmation employment and background checks.

We hope you will enjoy your experience at the college. Best wishes for a productive and successful career at BMCC.

Sincerely,

Gloria M. Chao
Director of Human Resources

/New Employee

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To: CANDIDATES FOR ECP POSITION

From: HUMAN RESCOURCES

Subject: APPOINTMENT AND PAYROLL AND PROCESSING

When you accept an offer of employment with the Borough of Manhattan Community College, you must present ORIGINAL documents as outlined in the attached.

Under federal law, you are required to complete and sign an Employment Eligibility verification form (Form I-9) in the presence of a designated representative in the Human Resources Office, Room S-717. You must complete the ECP Employment Packet and submit the required employment authorization documents to Human Recourses within 3 days of receiving your appointment letter or, if your start date is within three days of being hired, you must submit the documents immediately.

In addition, other documents for your appointment include the following:

1. All appointment forms (see attached)

   The Constitutional Oath is required for employment.
2. An Official college/university transcript of your highest earned degree. This original transcript must have the seal of the institution.
3. Social Security Card, for payroll purposes.

The Timing of your initial salary check will be based on the above process and our receipt of the completed Personnel Action Form (PAF) from your department. If you have any questions about the appointment or payroll process, please call us at (212) 220-8300.

Thank you

Review the following important Policies and Procedures by opening the links provided.

- CUNY Sexual Misconduct Policy
- Notice of Non-Discrimination
- CUNY Policies and Procedures on Equal Opportunity & Non-Discrimination
- Reasonable Accommodation Policy
- Office of Compliance and Diversity Informational Packet
- CUNY Lactation Room Policy
- Annual Security Report
- Students Bill of Rights
- CUNY Policy on Drug and Alcohol
- Acceptable use of computer resources
- Children on Campus
- Time Off for Religious Observance

Additional Policies and Procedures are available on the BMCC/HR and Office of Diversity websites for your examination.

The college is committed to ensuring a discriminatory free environment, where all persons are treated fairly and with respect regardless of his/her protected status. The **Office of Compliance & Diversity** is dedicated to promoting an open and inclusive environment, addressing complaints as they arise, creating programs which promote diversity and awareness and ensuring that the college complies with all applicable policies and laws.

Odelia Levy, Esq. is the college's Chief Diversity Officer. She also serves as the Coordinator for Title 504. You may reach Ms. Levy at olevy@bmcc.cuny.edu or (212) 220-1236.

Theresa B. Wade, Esq. is the college's Deputy Director of Diversity & Title IX Compliance and can be reached at twade@bmcc.cuny.edu or (212) 220-1273.

To file a complaint of unlawful discrimination or harassment, including sexual harassment, please contact Ms. Levy or Ms. Wade.

By signing below, I acknowledge that I have received, and familiarized myself with the above policies and reviewed the additional policies available on the BMCC website before commencing employment and agree to abide by their requirements.

_____ _____

Signature Date

_____

Print Name

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

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AMENDED CONSTITIUTIONAL OATH UPON APPOINTMENT

(In compliance with Section 62 of the New York State Civil Service Law)

"I hereby pledge and declare that I will support the Constitution of the United States and the Constitution of the State of New York and that I will faithfully discharge the duties of the Position of _____ according to the best of my ability"

Name: _____

Signature: _____

Address: _____

_____

_____

Date: _____

CUNY The City University of New York

Name

Position

College

Dept.

THE CITY UNIVERSITY OF NEW YORK EMPLOYMENT APPLICATION - PART TWO
POST-CONDITIONAL OFFER OF EMPLOYMENT

This form should be completed only after a conditional job offer has been made.

Post-Conditional Offer Verifications and Checks

Employment Eligibility and Identity Documents Verification

Newly hired employees must complete Section 1 of the Dept. of Homeland Security/U.S. Citizenship & Immigration Services I-9 Form **no later than the first day of employment.** CUNY is required to verify evidence of identity and employment authorization **within 3 business days of the employee's first day of employment.**

Verification of Credentials

Academic and professional credentials, as submitted in CUNY Employment Application Part 1, will be verified by the college.

Criminal Background Check

As a candidate with a conditional offer of employment, you must provide criminal background information. For some positions, a criminal history report may also be required. CUNY will consider your criminal history in accordance with Article 23-A of the New York State Correction Law.

A conviction record will not necessarily disqualify you from the position for which you are applying. However, failure to provide truthful responses will, when discovered, automatically result in the withdrawal of the conditional offer of employment or your termination, if employed.

Before any adverse action is taken based on a previous criminal conviction, CUNY will

- provide a written Article 23-A analysis to the candidate in a form determined by the New York City Commission on Human Rights (NYCCHR), together with any and all supporting information and/or documents which formed the basis and reasons for the adverse action; and
- after providing the candidate with the required documentation, allow him or her at least three business days to respond and, during that time, hold the position open for the candidate.

Credit History Check, Medical Certification, Medical Examination, Drug Screening, and Physical Agility and Fitness Assessment

For some positions, a credit history, medical certification, medical examination, drug test, and/or physical agility and fitness assessment may be required as a condition of employment. CUNY processes all information per applicable laws.

Accommodation required to perform Essential Job Functions

It is the University's policy to provide reasonable accommodations, when appropriate, to individuals with disabilities, individuals observing religious practices, employees who have pregnancy or child-birth related medical conditions, or employees who are victims of domestic violence/stalking/sex offenses.

If you require an accommodation to perform the essential job functions for the position for which you have received a conditional offer of employment, please contact the HR Director at the college or unit where you have received the conditional offer of employment.

THE CITY UNIVERSITY OF NEW YORK

APPLICATION FOR EMPLOYMENT - PART TWO

Application for Employment - Part Two (Confidential Background Information)
Only candidates who have received a conditional job offer should complete this form.

For questions and concerns, candidates may request guidance from the Office of Human Resources.

The completed form should be submitted to the Office of Human Resources only.

College _____ Job ID# _____ ☐ Full-time

Position _____ ☐ Part-time

Contract Title _____ A.M. _____

P.M. _____

Personal Information

Last Name _____ First Name _____ Middle Initial _____

If known by another name, please provide _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____ Daytime Phone # _____

e-mail _____ Evening Phone # _____

Please complete Page 3

Confidential Criminal Background Information:

1. Have you ever been convicted of a misdemeanor or felony? Even if you were convicted, answer "NO" if your conviction:
(a) was sealed, expunged, or reversed on appeal;
(b) was for a violation, infraction, or other petty offense such as "disorderly conduct";
(c) resulted in a youthful offender or juvenile delinquency finding; or
(d) if you withdrew your plea after completing a court program and were not convicted of a misdemeanor or felony.

☐ Yes ☐ No

2. Are there any criminal charges **currently** pending against you?

☐ Yes ☐ No

3. Please explain below **all** past convictions or currently pending criminal charges against you (as specified in Questions 1 and 2 above).
Attach additional pages, as necessary.

Offense		Date of conviction		Name and location of Court		Disposition including incarceration	
Offense		Date of conviction		Name and location of Court		Disposition including incarceration	
Offense		Date of conviction		Name and location of Court		Disposition including incarceration	
Offense		Date of conviction		Name and location of Court		Disposition including incarceration	

Applicant Attestation:

By my signature below, I declare and affirm that I have read and fully understand that:

Any misrepresentation or material omission of facts on this form shall be sufficient cause to end further consideration of my candidacy for the position for which I have received a conditional offer of employment or shall be sufficient cause for disciplinary action up to and including termination, in the event I am hired.

Signature _____ Date _____

COLLEGE USE ONLY

Received by the Director of Human Resources

Name _____ Date _____

Signature _____

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Primary: Name of Emergency Contact: _____

Relationship: _____

Address: _____

Home Phone Number: _____

Business Number: _____

Cell Phone Number: _____

Secondary: Name of Emergency Contact: _____

Relationship: _____

Address: _____

Home Phone Number: _____

Business Number: _____

Cell Phone Number: _____

_____ _____

Name (Print) Department

_____ _____

Signature Date

Borough of Manhattan Community College
Office of Human Resources
Personnel Information Form

_____ _____
Name (print) **Social Security Number**

_____ _____ _____
Title **Department** **Date of Appointment**

☐ **Female** ☐ **Male** ☐ **Other** _____ **Date of Birth**_____

Ethnicity:

☐ **African American** ☐ **Alaskan Native** ☐ **American Indian** ☐ **Asian**

☐ **Black** ☐ **Hispanic** ☐ **Italian American**

☐ **Pacific Islander** ☐ **Puerto Rican** ☐ **White** ☐ **Other** _____

U.S. Citizen: ☐ Yes ☐ No **If you are not a U.S. Citizen,**

Of what country are you a citizen? _____

What type of VISA are you holding: _____ **Expiration Date:** _____

Are you a Veteran? ☐ Yes ☐ No **If you are a veteran, please specify:**

☐ **Active Reserve** ☐ **Disabled** ☐ **Disabled Vietnam Era**

☐ **Inactive Reserve** ☐ **Retired** ☐ **Vietnam Era**

Home Address: _____
(print)
_____

Telephone Number: _____ **E-Mail Address** _____

Emergency Contact: _____ **Relationship:** _____

Address: _____

Telephone Number: _____ **Alternate Phone Number:** _____

Education: **Degree** **Major** **Date Earned** **Institution**_____

_____

_____

_____

To be completed by the Office of Human Resources

I-9 Date: _____ **Work Authorization Expiration Date:** _____ **Staff Initial**_____ **Date:** _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ► ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) _____ **Date** _____

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial	Last name	Your Social Security number
Permanent home address *(number and street or rural route)*	Apartment number	Single or Head of household ☐ Married ☐
		Married, but withhold at higher single rate ☐
City, village, or post office	State / ZIP code	**Note:** If married but legally separated, mark an ***X*** in the *Single or Head of household* box.

Are you a resident of New York City? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

Complete the worksheet on page 4 before making any entries.

1 Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 19)*	**1**	
2 Total number of allowances for New York City *(from line 31)*	**2**	

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3 New York State amount	**3**	
4 New York City amount	**4**	
5 Yonkers amount	**5**	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date

Penalty – A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an ***X*** in box A and/or box B to indicate why you are sending a copy of this form to New York State *(see instructions)*:

A Employee claimed more than 14 exemption allowances for NYS ..... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mm-dd-yyyy) (see instr.)*: ☐

Are dependent health insurance benefits available for this employee? ..... Yes ☐ No ☐

If *Yes*, enter the date the employee qualifies *(mm-dd-yyyy)*: ☐

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)*	Employer identification number

Instructions

Important information

The 2021-2022 New York State budget was signed into law on April 19, 2021. Changes to New York State personal income tax have caused withholding tax changes for taxpayers with taxable income:

- more than $2,155,350, and who are married filing jointly or a qualified widow(er);
- more than $1,077,550, and who are single or married filing separately; or
- more than $1,616,450, and who are head of household.

Accordingly, if you previously filed a Form IT-2104 and earn more than the amounts listed above, you should complete a new 2022 Form IT-2104 and give it to your employer.

Changes effective for 2022

Form IT-2104 has been revised for tax year 2022. The worksheet on page 4 and the charts beginning on page 5, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2022 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If the federal Form W-4 you most recently submitted to your employer was for tax year 2019 or earlier, and you did not file Form IT-2104, your employer may use the same number of allowances you claimed on your federal Form W-4. Due to differences in federal and New York State tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

For tax years 2020 or later, withholding allowances are no longer reported on federal Form W-4. Therefore, if you submit a federal Form W-4 to your employer for tax year 2020 or later, and you do not file Form IT-2104, your employer may use zero as your number of allowances. This may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or

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ECP Voluntary benefits:

Health Benefits
For detailed information please visit the BMCC Benefits website or contact the Benefits Office in S717.

Retirement Benefits
You are eligible to enroll in the Teachers' Retirement System of the City of New York (TRS), the ORP (TIAA), or the New York City Employees' retirement System (NYCERS). For enrollment forms and further information, please contact the HR Benefits Office.

Tax-Deferred Annuity Plans
You may participate in a tax-deferred annuity (TDA) plan with TIAA-CREF, or the Teachers' Retirement System of the City of New York (TRS) if you are a TRS member. The TDA plan allows you to set aside pre or post-tax dollars in a supplemental retirement account subject to the annual maximum IRS limit. For additional information on TIAA-CREF, please contact the Benefits office. For information regarding the TRS TDA plan, please contact TRS directly at 888-869-2877.

New York State Deferred Compensation 457(b) Plan
The NYSDCP 457(b) Plan is a voluntary, supplemental retirement savings plan offered by New York State. Employees have two options:

• Tax-Deferred Contributions – not subject to current federal or New York State income taxes; contributions and any earnings grow tax deferred; withdrawals will be taxed as ordinary income when you may be in a lower tax bracket (generally at retirement).

• Roth After-Tax Contributions – contributions are made after tax so withdrawals are tax free (as long as you're at least age 59½ and do not take withdrawals from your Roth account for at least five years after your first Roth contribution is made to the plan). For more information, please visit the NYSDCP 457(b) website at https://www.nysdcp.com/iApp/tcm/nysdcp/about/index.jsp

Transit Benefits
The Transit Benefit allows you to reserve pre-tax dollars for your travel needs. For additional information please reference the HR Benefits website or contact the HR Benefits office in Room S717. Enrollment forms for the TRANSITBENEFIT Plan, or the Park-N-Ride Plan may be found on the HR Benefits website.

CUNY Work/Life Program
This employee assistance program is a voluntary, free and confidential benefit for employees and their family members. Services are available 24 hours a day, 7 days a week. For additional information, please call 1-855-492-3633 or visit the CUNY Work/Life Program website at www.deeroaks.com to log in use Company Code: BMCC Password: BMCC.

Any questions please contact the Benefits Manager.

IMPORTANT

HEALTH PLAN COVERAGE FOR EMPLOYEES HIRED ON OR AFTER JULY 1, 2019

City of New York employees, and employees of Participating Employers, hired on or after July 1, 2019 will only be eligible to enroll in the Emblem Health **HIP HMO Preferred Plan** and must remain in the HIP HMO Preferred Plan for the first year (365 days) of employment.

Within the 335th day and 365th day of employment, the employee will have the option of either remaining in the HIP HMO Preferred Plan or selecting a different health plan. If a new health plan is selected, the new plan will be effective on the 366th day. Paperwork must be completed and submitted to the employees Benefits Officer within those 30 days leading to the 365th day of employment.

A newly hired employee who needs to request an exemption from the required enrollment in the HIP HMO Preferred Plan can do so by submitting a HIP HMO Opt-Out Request Form to **Emblem Health**. An employee, or eligible dependent, must meet certain criteria and the request must be approved by Emblem Health before the exemption is granted by your employer. The HIP HMO Opt-Out Request Form and HIP service area are available on the Emblem Health website.

In addition, after the 365th day of employment an employee can participate in an Annual Fall Transfer Period to select a different plan.

This information can also be found on the New York City Office of Labor Relations – Health Benefits website. A description of the plans are available under “Summary of Plans”.

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** ❑ **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
- ❑ Other:_____
- ❑ Add Optional Benefits
- ❑ Cancel Benefits (CHECK ONE)
  - ❑ Waive Benefits
  - ❑ Buy-Out Waiver Program (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: ❑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:	Medicare Claim Number:	❑If Medicare Part A - Effective Date: / / ❑If Medicare Part B - Effective Date: / /	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 Medicare Part A - Effective Date: / / ❑If Medicare Part B - Effective Date: / /
	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.)

					Check if Applicable		
Last Name:	First Name:	Date of Birth:	Social Security Number:	Sex:	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:
	/ /	( ) -

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

The City University of New York

RETIREMENT PROGRAM ELECTION FORM
For Full-Time Staff / Civil Service Managers

This form is to be used for eligible employees of CUNY who are appointed, promoted, transferred or re-classified to an eligible Full-time Staff / Classified Managerial position and **must be filed within 30 days** of written notification of eligibility. For those electing the Optional Retirement Program (ORP), you must submit this form and enroll with TIAA-CREF online. **New employees who do not complete the election process within the statutory time frame noted in the attached information sheet are by law forced into membership with TRS or, if Classified Managerial, into NYCERS.**

Section 1: Personal Information

Name: _____ Social Security Number: _____

Home Address: _____

College: BMCC/CUNY Job Title: _____ Pension Member # (if any): _____

Section 2: Election of Retirement Program

Having received written notification of my retirement system options and having satisfied myself as to the desired retirement system available to me by or pursuant to law in connection with my employment by the City University of New York, I hereby make the following election in regard to my participation in the retirement program as specified below (check one only)

I. _____ **The Optional Retirement Program (ORP) –** I understand that in addition to notifying my employer of my election, I must also enroll with TIAA online (www.tiaa.org/cuny)

II. _____ **Teachers' Retirement System of The City of New York (TRS) –** For Instructional Staff only, unless already a member of the NYC TRS through a former position in public service.

III. _____ **The New York City Employees' Retirement System (NYCERS) –** Classified Managerial only, unless already a member of NYCERS through a former position in public service**.**

IV. _____ **The Board of Education Retirement System*** (for current members only);

V. _____ I have been appointed to a **Substitute or Visiting** Professor title and opt not to join the ORP or TRS; therefore, I choose not to be a member of a pension system at this time.

Signature **Name (Print)** **Date** **HR Office Verification**

☐ Those participating as Transferred Contributors please check here

Enrollment Form

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

A copy of your NYC Health Benefits Application is required and/or WF Domestic Partner form if Applicable.

Dependent information will be obtained from your NYC Health Application unless you indicate otherwise.

Member

NYSUT ID: _____ NYS ID (State Colleges): _____

Social Security : _____ Date of Birth: ___/___/___

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Marital Status: ☐ S ☐ M ☐ DP Gender: ☐ F ☐ M

Primary Telephone: (___) _____ Primary Email: _____

Dental

For more information visit: www.psccunywf.org

Guardian ☐

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

Health Plan

_____ Basic ☐ Rider ☐ Waived ☐ Stipend ☐

Member

I hereby certify that all of my personal information presented here is true and accurate.

_____

Signature Date

College

_____

CUNY Campus

Effective Date of Coverage ___/___/___

_____

Job Title and Code

Effective Date of Hire ___/___/___

Earliest CUNY Hire Date ___/___/___

_____

Previous College (if applicable)

If Classified Managerial check here ☐

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

PSC-CUNY Welfare Fund Death Benefit Beneficiary Designation Card

Name of Employee (Last) (First) Middle Initial		
Social Security Number	Male ☐ Female ☐	Date of Birth Mo. Day Yr. 19
Name of College:		
Date employed:		Job title
Primary Beneficiary Name	Telephone number relation to me	
Primary Beneficiary Address,		
Contingent Beneficiary Name	Telephone number relation to me	
Contingent Beneficiary Address,		
Date Signed Mo. Day Yr.	Signature of Employee	

Order of Payment and Division of Benefits. Unless otherwise provided:

(a) Payment at my death is to be made to a primary beneficiary if he/she is then living.

(b) Payment at my death is to be made to a contingent beneficiary if he/she is then living and there is no primary beneficiary then living.

(c) If all beneficiaries predecease me, the benefits will be payable to my estate.

Human Resources

Borough of Manhattan Community College
The City University of New York
www.bmcc.cuny.edu

199 Chambers Street
New York, NY 10007-1097
tel. 212-220-8300
fax 212-220-2364

ECP Packet Checklist

You must present ORIGINAL documents as outlined below to the HR Office.

□ **Completed New Hire Packet**
□ **Proof of Identity and Employment Eligibility**
Under federal law you must complete an Employment Verification (I-9) form in the presence of an HR officer. Be sure to bring appropriate proof of identity/eligibility to HR before your first day of work.

□ **Social Security Card (for Payroll purposes)**
□ **Official Transcript of highest earned degree (sealed envelope or E-Transcript) directly from the school**

If applicable, complete and return:

□ Direct Deposit of Net Pay Enrollment

□ BMCC Computer System Accounts

□ TRANSITBENEFIT Plan

□ Park-N-Ride Plan

By signing below, I acknowledge that I have received, and familiarized myself with the BMCC policies, agree to abide by their requirements, and have provided the needed documents.

The timing of your initial pay check will be based on the process and our receipt of the above documents. If you have any questions about your appointment or payroll process, please call us at 212-220-8300.

_____ _____

Print Name **Date**

_____

Signature