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: ( ) -