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,

Human Resources

/New Employee

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Full Time Instructional Staff/Faculty

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

☐ **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**
☐ **Employee's Withholding Allowance Certificate (W-4 and IT-2104)**
☐ **Curriculum Vitae (Faculty)**
☐ **Health Benefits Application**
☐ **Three letters of reference**
☐ **PSC-CUNY Welfare Fund Datasheet**
☐ **Original Transcript (highest degree)**
☐ **Retirement Program Election Form**
☐ **CUNY Employment Application –Part 2**
☐ **Death Benefit Beneficiary Designation Card**
☐ **Personnel Information Form**
☐ **Emergency Contact**
☐ **Amended Constitutional Oath Upon Appointment**

If applicable, complete and return:

☐ **Direct Deposit of Net Pay Enrollment**

☐ **Transit Benefit Enrollment**

Please take time to familiarize yourself with the following:
- TIAA-CREF enrollment instructions
- A comparison of pension plans
- Departmental Mailboxes and E-mail Accounts
- BMCC Policies & Procedures on the HR Website
- Students Bill of Rights
- Annual Security report

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

BOROUGH OF MANHATTAN COMMUNITY COLLEGE

The City University of New York
IMMIGRATION REFORM AND
CONTROL ACT OF 1986

EMPLOYMENT ELIGIBILITY VERIFICATION INFORMATION

Among other changes, the Immigration Reform and Control Act of 1986 creates a national employment verification system which places responsibility for verification of the identity and employment eligibility of all employees on the employer. Effective June 1, 1987 this new law requires employers to request and examine original documentation pertaining to the identity and employment eligibility of all new hires and rehires, including U.S. citizens, permanent residents, and non-immigrant visa holders.

Should you accept an offer of employment with the Borough of Manhattan Community College, you must present **ORIGINAL** documentation, outlines on the next page of the document, on or before your first day of work.

After these documents are reviewed, you will then be required to complete and sign an Employment Eligibility Verification Form (Form I9) in the presence of the designated representative of the College.

Should you accept an offer of employment with the College, this process should be completed on or before your first day of work. Otherwise, your employment at the College will be jeopardized.

If you have any questions concerning the employment process at Borough of Manhattan Community College, please call **Human Resources Office, 212-220-8300**

Please 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
- CUNY Lactation Room Policy
- Annual Security Report
- CUNY Policy on Drug and Alcohol
- Acceptable use of computer resources
- Children on Campus
- Time Off for Breast and Prostate Cancer Screenings and Donating Blood
- 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

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

Name (print) _____ **Social Security Number** _____ **Date of Birth** _____

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

Select one of the following ☐ **Male** ☐ **Female** ☐ **Transgender** ☐ **Gender Nonconforming** ☐ **Non-Binary**
☐ **A gender not listed** ☐ **X** ☐ **Not Specified (removing gender information)**

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:** _____

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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: _____

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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

New Employee On-Boarding & Existing Employee Orientation for IT Security

Why is IT Security important at CUNY?

- We must ensure our academic and administrative systems continue to be available to run the business of the University and to serve our faculty, students, and staff
- We must maintain accurate University data and prevent unauthorized changes (g.g., grades, financial aid information).
- We must be reputable custodians and are required by law to protect the privacy of personal data belonging to our faculty, students, and staff.

What are the IT security risks to CUNY?

- Don't be phished. Phishing is a scam in which an e-mail message directs you to click on a link that takes you to a web site where you are prompted for personal information, such as passwords, social security number, bank account number or credit card number. Both the link and the web site may closely resemble an authentic web site, but they are not legitimate.
- Don't disclose personal information to someone you don't know. Social engineering is an approach to gain access to information through misrepresentation. It is the conscious manipulation of people to obtain information without their realizing that a security breach is occurring. It may take the form of impersonation via telephone or in person, and through e-mail.
- Don't disclose personal information within CUNY unless it is absolutely necessary. The need for disclosing your social security number ouside of the Human Resources (HR) department would be unusual. When in doubt, contact the HR department directly to verify the legitimacy of the request.
- Protect your user ID and password and never share them. Your user ID is your identification, and it is what links you to your actions on CUNY's computer systems. Your password authenticates your user ID. Use passwords that are difficult to guess the change them regularly.
- You are responsible for actions taken with your ID and password. Log off or lock your computer when you are away from your workstation. In most cases, hitting the "Control-Alt-Delete" keys and then selecting "Lock Computer" will keep other out. You will need your password to sign back in, but doing this several times a day will help you to remember your password.
- E-mail and portable devices are not secure. Do not ship personal information belonging to you or CUNY faculty, students and staff to portable devices (e.g., portable hard drives, memory) or send or request to be sent such personal information in an e-mail text or as an email attachment without encryption.
- Be careful when using Internet. Malicious code can take forms such as a virus, worm, or Trojan and can be hidden behind an infected web page or a downloaded program. Keep an anti-virus and anti-malware programs and the software on your workstation up-to-date at all times. Only install software authorized by your department, and never disable or change security programs and their configuration.

Where are the CUNY IT Security information resources?

- Security.cuny.edu is available 24 hours a day from any Internet accessible location without a user ID and password. All relevant policies, procedures, and advisories, the IT Security awareness program and materials, and links to external IT security information resources are located here.
- Find the Policy on Acceptable Use of Computer Resources under Info Security Policies.
- Find the IT Security Procedures-General under Info Security Policies.
- To take the IT Security Awareness tutorial, approximately 30 minutes, click on the padlock on the home page of security.cuny.edu.

Who to contact for help with IT Security at CUNY?

- Your Supervisor
- Your College Web-site
- security.cuny.edu
- The College IT Security Manager (click on Campus Security Managers Contact Information at security.cuny.edu under Contact Us).
- The College Chief Information Officer or equivalent in the Central Office department.
- The CUNY Central IT Security Office at security@mail.cuny.edu or the Contact us page at security.cuny.edu or the Who to Contact for Help page at security.cuny.edu

Where are some external resources for help with IT Security located?

- New York State Office of Cyber Security and Critical Infrastructure Coordination (CSCIC) at www.csic.state.ny.us
- Federal trade Commission at www.ftc.gov
- Privacy Rights Clearinghouse-Nonprofit Consumer Information and Advocacy Organization at www.privacyrights.org
- Anit-Phishing working Group-Committed to wiping out Internet scams and fraud at **www.antiphishing.org**
- Microsoft Malware protection Center, Threat Research and Response at www.microsoft.com/security/portal

What is required of me as an employee of CUNY?

- Acknowledge, by signature below, receipt of the Policy on Acceptable Use of Computer Resources.
- Acknowledge, by signature below, receipt of the IT Security Procedures-General.
- Complete the IT Security Awareness tutorial within the first 30 days of employment.
- Maintain compliance with the Policy on Acceptable Use of Computer resources and the IT Security Procedures at all times.

If you discover or suspect a security breach, you should report the incident to your supervisor, the college IT Security Manager (click on Contact Us at security.cuny.edu) and the CUNY Central IT Security Office (security @mail.cuny.edu) immediately.

I hearby ackonoledge receipt of the Policy on Acceptable Use of Computer Resources and the IT Security Procedures-General.

_____ _____

(Printed Name) (Signed)

Borough Of Manhattan Community College _____

(College/business area) (Date)

One copy for personnel file
One copy to employee
VO2, July 2010

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

2023

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 surviving spouse**
☐ **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, other details, 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) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

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 Dependent and Other Credits

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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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

2023

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 ☐

Before making any entries, see the *Note* below, and if applicable, complete the worksheet in the instructions.

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

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's signature	Date

Employee: Give this form to your employer and keep a copy for your records. Remember to review this form once a year and update it if needed.

Note: Single taxpayers with one job and zero dependents, enter ***1*** on lines 1 and 2 (if applicable). Married taxpayers with or without dependents, heads of household or taxpayers that expect to itemize deductions or claim tax credits, or both, complete the worksheet in the instructions. Visit *www.tax.ny.gov* (search: *IT-2104-I)* or scan the QR code below.

Employer: Keep this certificate with your records.

If any of the following apply, mark an ***X*** in each corresponding box, complete the additional information requested, and send an additional copy of this form to New York State. See ***Employer*** in the instructions. Visit *www.tax.nys.gov* (search: *IT-2104-I)* or scan the QR code below.

A Employee claimed more than 14 exemption allowances for New York State ..... A ☐

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

You may report new hire information online instead of mailing the form to New York State. Visit *www.nynewhire.com*.

Note: Employers **must** report individuals under an **independent contractor arrangement** with contracts in excess of $2,500 using the online reporting website above, **not** Form IT-2104.

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 New York State Tax Department.)*	Employer identification number

Scan here

https://www.tax.ny.gov/r/it2104i-2023

THE CITY OF NEW YORK PAYROLL MANAGEMENT SYSTEM **DIRECT DEPOSIT OF NET PAY** Enrollment/Cancellation	SUBMIT COMPLETED FORM TO: YOUR AGENCY DIRECT DEPOSIT COORDINATOR OR YOUR PAYROLL OFFICE www.NYC.gov/payroll

TYPE OF ACTION

Attach a voided check or most recent savings statement. Check all that apply.

☐ New Enrollment ☐ Cancelation ☐ Change of Name on Account ☐ Change of Account Number ☐ Change of Account Type ☐ Change of ABA Number

EMPLOYEE SECTION

EMPLOYEE IDENTIFICATION

FIRST M.I. LAST

SOCIAL SECURITY NUMBER ___-___-____

WORK TELEPHONE ___-___-____

Enrollment

PERSON(S) NAMED ON ACCOUNT (PRINT EXACTLY-INCLUDE TRUSTEE OR HOINT OWNER):

PERSON 1

PERSON 2

ABA NUMBER* **ACCOUNT NUMBER**** **ACCOUNT TYPE** (CHECK ONLY ONE) ☐ SAVINGS ☐ CHECKING

***ABA BANK NUMBER:** CHECKING ACCOUNTS—The ABA number is the first nine(9) numbers prior to the account number at the bottom left corner of the check

SAVINGS ACCOUNTS---Contact your bank for ABA number, if not known.

EMPLOYEE AUTHORIZATION

I hereby authorize The City of New York to deposit my net pay directly into my checking or savings account as requested. I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the "National Automated Clearing House Association" operating guidelines and rules. The City of New York can only reverse the amount of the incorrect direct deposit. I agree that this authorization will remain in effect until I provide to my agency a written cancelation to terminate the service.

Employee Signature _____ Date ___/___/___

Cancelation

I hereby authorize The City of New York to cancel my direct deposit agreement.

Employee Signature _____ Date ___/___/___

AGENCY PAYROLL SECTION

DOCUMENT # | **CHECK DIGIT** | **JSN** | **PAYROLL**

ENROLLMENT REJECTION REASONS: ☐ INACTIVE LEAVE STATUS ☐ PAYCYCLE IS "A" ☐ OTHER _____

AGENCY REP NAME (PLEASE PRINT) _____ SIGNATURE _____ DATE _____

DATA ENTRY OPERATOR NAME (PLEASE PRINT) _____ SIGNATURE _____ DATE _____

IMPORTANT

HEALTH PLAN COVERAGE FOR EMPLOYEES HIRED ON OR AFTER OCTOBER 1, 2022

City of New York employees and employees of Participating Employers*, hired on or after October 1, 2022, and their eligible dependents, will only be eligible to enroll in the EmblemHealth HIP HMO Preferred Plan and must remain in the HIP HMO Preferred Plan for the first year (365 days) of employment.

After 365 days of employment, the employee will have the option of either remaining in the HIP HMO Preferred Plan or selecting a different health plan within 30 days before the end of the 365-day period. If a new health plan is selected, the new plan will be effective on the 366th day.

Only after the 365th day can the employee participate in any Annual Fall Transfer Period. (See the Annual Fall Transfer Period section below for details.)

An 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 EmblemHealth directly. An employee, or eligible dependent, must meet specific criteria in order to submit the request, and EmblemHealth must approve it before the exemption is granted. The HIP HMO Opt-Out Request Form and HIP HMO service area are available on the EmblemHealth website.

CITY OF NEW YORK

NEW EMPLOYEE HIP HMO OPT-OUT REQUEST FORM

Pursuant to the New York City Health Benefits Summary Program Description, all City of New York employees and employees of Participating Employers hired on or after October 1, 2022, will only be eligible to enroll in the EmblemHealth HIP HMO Preferred Plan and must remain in the HIP HMO Preferred Plan for the first 365 days of employment.

An employee who needs to request an exemption to this requirement can do so by submitting this completed Opt-Out Request Form to EmblemHealth, via the email address provided below. An employee or eligible dependent must meet the criteria outlined below, and EmblemHealth must approve the request before the exemption is granted.

Criteria for Opt-Out (Check box below):

- ☐ The new employee resides outside the HIP HMO service area and cannot access primary care with one of the HMO providers. Visit https://www.emblemhealth.com/Members/City-of-New-York-Employees for a list of counties in the HIP HMO Service Area. Please provide your name and address on the following form.

- ☐ The new employee or eligible dependent is being treated by a non-network provider for a life-threatening or disabling disease or condition and is receiving ongoing treatment for a catastrophic or terminal illness or a condition requiring complex case management (such as ventilator dependence or trauma). Please provide the treating physician(s) name, address, and phone number on the following form.

Process:

New employees must complete and submit this New Employee HIP HMO Opt-Out Request Form immediately. *Please email completed* forms *to:* cityagencies@emblemhealth.com or fax *them to 212-510-5919.*

Once your Opt-Out Request Form has been reviewed and a determination has been made, *EmblemHealth will notify you via the email* address *you have provided on the back of this* form. *If you* are *approved, you must submit the approval notification to NYCAPS* or *your agency benefits representative.*

Please complete the following:

Employee Information

Employee Last Name: _____ Employee First Name: _____

Date of Birth: _____ Phone: _____

Email Address: _____

Home Address: _____ Home Zip: _____

Agency: _____ Date of Hire: _____

Dependent Information:

(If the request for exemption is due to an eligible dependent, please also provide the following.]

Dependent's Last Name: _____ Dependent's First Name: _____

Dependent's Date of Birth: _____

Medical Information (Please check one):

Self Dependent

Treating Physician's Name: _____

Physician's Phone: _____

Physician's Address: _____

Diagnosis/Condition: _____

EMPLOYEE/DEPENDENT'S SIGNATURE AND RELEASE (this form must be signed to be processed)

I hereby request exemption from the above City Health Benefits Program requirement and certify that the above information is complete, true, and correct. I authorize above listed physicians and other medical professionals to provide EmblemHealth with information concerning medical care, advice, treatment, or supplies provided to the Employee or eligible dependent. I understand that this authorization will be used only for the purpose of obtaining information, and the duration of the authorization will be limited, to determine whether the employee or eligible dependent meets the criteria outlined above. I agree that a photostatic copy of this authorization is as valid as the original.

Employee Signature: _____ Date: _____

Dependent's Signature (if dependent is not a minor) _____ Date: _____

FOR OFFICIAL USE ONLY
☐ • Approval
☐ • Denial - does not meet criteria
Date:

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:	Appointment/Retirement Date:	Pay Period:	Effective Date of Coverage:
		❑ Full-Time ❑ Permanent ❑ Part-Time ❑ Provisional	/ /	❑ Weekly ❑ Monthly ❑ Bi-Weekly ❑ Semi-Monthly	/ /

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

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

New York City
Health Benefits Program
Dependent Eligibility Required Documentation

Below is a list of all dependent eligibility documentation requirements for health benefits coverage for dependents.

For a Spouse

- married one year or less – Government Issued Marriage Certificate
- married more than one year – Government Issued Marriage Certificate and one of the following:
    - Federal tax return filed within last two years and listing spouse as joint or individual
    - Proof of joint ownership (bank account, auto, home, etc.) issued within last six months
    - Proof of cohabitation (two separate documents – one in your name and one in your spouse's name – at the same address, such as utility bills, bank statements or credit card statements)

For a Domestic Partner

- partnership of one year or less – Domestic Partnership Certificate of Registration
- partnership of more than one year – Domestic Partnership Certificate of Registration and one of the following:
    - Proof of joint ownership (bank account, auto, home, etc.) issued within last six months
    - Proof of cohabitation (two separate documents – one in your name and one in your domestic partner's name – at the same address, such as utility bills, bank statements or credit card statements)

For a Child

NOTE: Disabled status for any child still requires current medical certification from the health plan in addition to the documents listed below.

- Biological Child
    - Government Issued Birth Certificate (including parent's names)

- Step Child – Must be spouse's child. One of the following combinations of documents is required:
    - Government Issued Birth Certificate (including parent's names) and Government Issued Marriage Certificate if married one year or less
    - Government Issued Birth Certificate (including parent's names) and Government Issued Marriage Certificate and Federal tax return filed within last two years listing spouse as joint or individual
    - Government Issued Birth Certificate (including parent's names) and Government Issued Marriage Certificate and proof of joint ownership (bank account, auto, home, etc.) issued within last six months

- Domestic Partner's child – Must be registered domestic partner's child. One of the following combinations of documents is required:
    - Government Issued Birth Certificate (including parent's names) and Domestic Partnership Certificate of Registration if partnership of one year or less
    - Government Issued Birth Certificate (including parent's names) and Domestic Partnership Certificate of Registration and proof of joint ownership (bank account, auto, home, etc.) issued within last six months

- Legal Ward
    - Government Issued Birth Certificate and the court ordered document of legal custody

- Tax Dependent Child
    - Government Issued Birth Certificate and the federal tax return filed in the previous year listing child as dependent

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 ___ / ___ / ___

If Classified Managerial check here ☐

_____
Previous College (if applicable)

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.
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.

PSCcuny/ *Professional Staff Congress / City University of New York*
61 Broadway, Suite 1500 • New York, New York 10006 • 212/354-1252 • Fax 212/302-7815
Visit our website at http://www.psc-cuny.org

CHOOSING A PENSION PLAN: A GUIDE FOR NEW MEMBERS (Tier VI)

New York State law mandates participation in a retirement system for full-time members of the instructional staff. New staff members have 30 days from the effective date of their appointment to choose a retirement program, and the choice is irrevocable. If no choice is filed within 30 days, the law mandates that the member be assigned to the New York City Teachers' Retirement System (TRS).

Full-time instructional staff members must choose between the New York City Teachers' Retirement System (TRS) and the Optional Retirement Program (ORP). Those who elect the Optional Retirement Program must choose investment options through either Teachers Insurance and Annuity Association-College Retirement Equities Fund (TIAA-CREF) or through the alternate funding vehicles offered by Guardian or MetLife. More information may be obtained from your college HR Office.

Adjuncts employed by CUNY are only eligible for membership in TRS and may join at their option. Additional information on choosing a pension plan is available from Jared Herst, PSC Coordinator of Pension and Welfare Benefits, at (212) 354-1252, or jherst@pscmail.org. This chart, which compares the two systems, may assist new members in choosing their pension plan.

CUNY's Pension Options

System	New York City Teachers' Retirement System (TRS)	Optional Retirement Program
Type of Basic Retirement Plan	**Defined benefit plan:** Benefits are based on age, Final Average Salary* (FAS) and years of employment. *Final Average Salary (FAS): Average of your highest five consecutive annual salaries with certain limitations.	**Defined contribution plan:** Benefits are based on the amounts contributed by the employer and employee and earnings of the employee's choice of investments.
Vesting	After five years of total credited service.	After 366 days of continuous full-time employment. (Immediate if employee has a pre-existing, vested TIAA-CREF Retirement Annuity (RA) or Group Retirement Annuity (GRA) contract.)
Retirement Age	**Age 63:** Immediate, unreduced benefits. **Ages 55 to 62:** Immediate, reduced benefits at 6.5% per year between those ages.	**No age limitation:** A member may choose to retire and begin annuity income after vesting without a reduction in benefits.
NYC Retirement Health Benefits	Full-time CUNY employees with 10 years of credited service, age 55 or older and receiving a pension. Health insurance premiums are deducted from employees' basic pension payouts in retirement.	A member with at least 15 years of pensionable, continuous, full-time CUNY service and who is at least age 62. **Note:** As of 9/1/05, if you are a health-benefits-eligible retiree, you are required to maintain $50,000 in reserve, with TIAA-CREF, in order to pay for retiree health insurance premiums. Additional reserve amounts may be required depending on the health plan you select or to cover future insurance rate increases.

System	New York City Teachers' Retirement System (TRS)	Optional Retirement Program
Retirement Allowances	**For members who join TRS after 3/31/2012:** **Less than 20 years of service:** 1.67% x FAS x years of service. **20 years of service:** 1.75% x FAS x years of service. **More than 20 years of service:** 1.75% x FAS x years of service (for first 20 years) + 2% FAS for each year of total service credit above 20.	Retirement benefits are based on total accumulations, age at retirement, and the income options selected.
Contribution Rates	Employee pays 3% of regular compensation on a federally tax-deferred basis through 3/31/2013. Thereafter, the contribution rate varies for the remainder of service, dependent upon an employee's salary: --$45,000 or less: 3.00% --More than $45,000 to $55,000: 3.50% --More than $55,000 to $75,000: 4.50% --More than $75,000 to $100,000: 5.75% --More than $100,000: 6.00% Employer contributes a lump-sum annually to TRS.	Employee pays 3% of regular compensation on a federally tax-deferred basis through 3/31/2013 Thereafter, the contribution rate varies for the remainder of service, dependent upon an employee's salary: --$45,000 or less: 3.00% --More than $45,000 to $55,000: 3.50% --More than $55,000 to $75,000: 4.50% --More than $75,000 to $100,000: 5.75% --More than $100,000: 6.00% Employer pays 8% of salary for first seven years of employment and 10% thereafter until the remainder of the employee's service.
Tax-Deferred Annuity (TDA)	Voluntary TRS TDA 403(b) is available for members of TRS basic retirement plan.	Voluntary TIAA-CREF TDA 403(b) is available.
	Note that other tax-deferred retirement investment options are also available. For more information, contact your campus HR benefits officer or reach out to Jared Herst at PSC-CUNY.	
Retirement Disability Benefits	**Ordinary Disability benefits:** 10 or more years of service credit required. **Accident Disability Benefits:** No minimum service requirement.	A member who has been certified disabled and retires may receive annuity payments and city-provided health benefits after 10 years of full-time service.
Death Benefit: Beneficiar(ies) of <u>Active</u> Employees in Basic Pension.	Member contribution accumulation (member contributions + interest) + death benefit equal to one year's salary for one year of service, two years' salary for two years of service and three years' salary for three or more. Reductions may be applicable depending on age.	Total accumulations in a member's basic retirement plan.
Loans	Yes, to the maximum allowable by law from a member's contributions to basic retirement plan, TDA, 457(b) and 401(k) plans.	Yes, to the maximum allowable by law from a member's basic retirement plan, TDA, 457(b) and 401(k) plans.

*The preceding is for informational purposes only. It is a preliminary interpretation of 2012 Tier VI legislation & subject to change.

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. **I must also enroll with TRS online (www.trsnyc.org)**

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

How to enroll

Enrollment eligibility and details for the CUNY Optional Retirement Program (ORP)

You have 30 days after the date of your hire to enroll. All full-time faculty and professional members (teaching and nonteaching or executive compensation plan employees) are eligible to choose between two plans: the NYC Teachers' Retirement System (TRS) Defined Benefit Plan or the Optional Retirement Program offered through TIAA. If you do not choose a plan within 30 days of employment, you will be automatically default enrolled into the Defined Benefit Plan.

Contribution information for the Optional Retirement Program

The City University of New York (CUNY) requires appointed members to contribute a certain percentage of base salary through regular payroll deductions as a condition of employment.

- CUNY contributes 8% of your salary for the first seven years of your employment and 10% for all subsequent years.
- New employees are required to contribute 3%-6% (pretax) of your salary through regular payroll deductions. See contribution table below:

Wages up to $45,000	3%
Wages $45,000.01 and up to $55,000	3.5%
Wages $55,000.01 and up to $75,000	4.5%
Wages $75,000.01 and up to $100,000	5.75%
Wages $100,000.01 and greater	6%

- Once you have completed 366 days of service with CUNY, you are fully vested in all retirement and death benefits provided by the investments purchased through both the University and your own contributions. The 366-day wait is waived for employees who enter service with a current, pre-existing vested TIAA retirement contract.

To learn more, visit TIAA.org/cuny.

Don't forget to join the CUNY Voluntary Savings Plan. Open a Tax-Deferred Annuity.

Contributing to a Tax-Deferred Annuity (TDA) can help you supplement the retirement income you can receive from your retirement plan and Social Security.

The TDA Plan may you to make pretax and Roth (after-tax) contributions to your retirement savings. Please ask your benefits administrator if Roth contributions are available.

The major difference between a Roth contribution option and a pretax contribution option is *when* you pay income taxes. With a pretax option, your contribution comes out of your paycheck before it is taxed. Pretax contributions lower your taxable income in the year of your contribution, and your contributions and earnings are tax deferred until you take them out of your TDA Plan account. With the Roth contribution option, your contribution is taken out of your paycheck after taxes are paid. Roth contributions do not lower your current taxable income. Your Roth contributions, and the accumulations on them, are not taxed when qualified withdrawals are made.*

How to enroll instructions are on next page.

Enrolling with the CUNY Optional Retirement Program

For information on enrollment eligibility and details on the CUNY Optional Retirement Program and Tax-Deferred Annuity Plan offered, please visit **TIAA.org/cuny**.

Before you begin to enroll, have handy your Social Security number, birth date and address, along with the same information for your beneficiary if you'd like to name one at this time.

Enrolling online is fast and simple:

Visit TIAA.org/cuny

- Select *Ready to Enroll*.
- Choose *Optional Retirement Program* (Employer Program) and then *Next*.
- Click *Begin Enrollment*.
- Arrive at the TIAA *Welcome* page where you can register for a user ID and password or enter your log-in information if you are already registered with TIAA.
- Enter your user ID and click *Log In* if you are a returning user.
- Or, click *Register with TIAA* if you are a first-time user.
- Select your school from the drop-down list.
- Follow the on-screen instructions. You will be asked for specific investment choices on the Allocation screen.
- When you arrive at the *Thank You* screen, your online enrollment is complete.
- You may want to print a copy of the confirmation for your records.

To enroll in the Tax-Deferred Annuity Plan visit TIAA.org/cuny.

You will need to complete a TDA enrollment application and then a Salary Reduction Agreement (SRA), which allows you to set up contributions directly from your paycheck to your retirement account. Return your completed SRA form and proof of enrollment to your campus benefits office. Federal law allows tax deferred savings up to $19,500 in 2020 and if you will be age 50 or over in 2020, you may contribute an additional $6,500, for a maximum of $26,000.

CUNY has dedicated representatives at TIAA who are trained to answer all of your questions about the retirement plan. Call **866-277-7957** to be connected with a representative. To schedule an in-person advice session with your dedicated financial consultant, go to **TIAA.org/schedulenow** and sign up.

* Withdrawals of earnings prior to age 59½ are subject to ordinary income tax, and a 10% penalty may apply. Earnings can be distributed tax free if distribution is no earlier than five years after contributions were first made and you meet at least one of the following conditions: Age 59½ or older or permanently disabled. Beneficiaries may receive a distribution in the event of your death.

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Commuter Benefit Solutions Edenred www.commuterbenefitsnyc.com

THE CITY OF NEW YORK COMMUTER BENEFITS PROGRAM

TRANSITBENEFIT PLANS

Submit completed form to: Your College TransitBenefit Coordinator www.cuny.edu/transitbenefit www.commuterbenefitsnyc.com

EMPLOYEE ACTION

☐ **NEW** (Enroll)
☐ **CHANGE PERSONAL INFORMATION** (Change Mailing address, Email or Telephone)
☐ **CHANGE DEDUCTION** (Change Transit Plan and/or Amount Deducted from Pay each Month)
☐ **SUSPEND DEDUCTION** (Temporarily Stop Transit Plan Deduction from Pay)
☐ **CANCELLATION** (Terminate Your Transit Plan Payroll Deduction)

EMPLOYEE IDENTIFICATION (All fields in this section are required and must be filled out completely. Please Print.)

Social Security / ERN	DOB MM_____ /DD_____/YYYY_____		
Name (First/Middle/Last)			
Address Line 1			
Address Line 2**			
City/ State/Zip			
Email Address		**Telephone**	

*Located on your pay statement or check stub. ** Apt.#, Fl.# or Box# if applicable.

TRANSIT PLAN AUTHORIZATION

(Please select One of the following plans by writing your initials in the column next to the Transit Plan of your choice. Please enter the total amount, including dollars and cents, you want deducted from your pay each month.)

ACCESS-A-RIDE ($2.05 Monthly Admin Fee through Payroll Deductions)		**COMMUTER CARD - Unrestricted** ($1.25 Monthly Admin Fee through Payroll Deductions)		**TRANSIT PASS** ($2.05 Monthly Admin Fee through Payroll Deductions)	
Employee Initials	**Monthly Deduction Amount***	Employee Initials	**Monthly Deduction Amount***	Employee Initials	**Monthly Deduction Amount***
	$		$		$

*For the Commuter Card-Unrestricted, Transit Pass and Access-A-Ride plans you may elect any amount up to $800.

SUSPEND TRANSIT PLAN DEDUCTION

Submit at least 2 weeks before you want to suspend your deduction. Remember, administrative deductions will continue when applicable. If you are also enrolled in the Commuter Benefits Parking Plan, the parking plan will be suspended for the same period. Please note this will only suspend your payroll deduction. To also suspend your transit pass orders you must do so directly with Edenred Commuter Benefit Solutions at www.commuterbenefitsnyc.com or (833) 584-8109.

PAY DATE TO SUSPEND DEDUCTION MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐☐☐

PAY DATE TO RESUME DEDUCTION MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐☐☐

EMPLOYEE CERTIFICATION

I hereby authorize The City University of New York to deposit my payroll deduction as indicated above into my ECBS Commuter Benefits Transit Account.

I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the "National Automated Clearing House Association" operating guidelines and rules, The City University of New York can only reverse the amount of the incorrect direct deposit.

I understand, according to the Internal Revenue Code, that the average monthly amount of my transportation deductions should not exceed my average monthly cost of public transportation to and from work. If my average monthly cost of public transportation to and from work should change, I will change my deduction plan to accommodate my new circumstance. Furthermore, no reimbursement will be provided for pre-tax transportation fringe deductions. Upon cancellation, voluntary or otherwise, any funds remaining in my Transit Account will be available for use for a period of 90 days from the effective date of cancellation. Residual funds remaining in the account beyond the 90 day period will be forfeited.
I understand there is a monthly fee to cover administrative costs of the program. Said fee will be deducted from my post-tax pay each month. The administrative charge is non-refundable. The administrative fees and charges are as follows:

TRANSIT PLAN	**FEE**	**CHARGE METHOD**
Access-A-Ride	**2.05**	**Deducted from post-tax pay**
Commuter Card-Unrestricted	**1.25**	**Deducted from post-tax pay**
Transit Pass	**2.05**	**Deducted from post-tax pay**

I grant authorization for The City University of New York to provide my enrollment information, including mailing address, phone number and e-mail address to Edenred Commuter Benefit Solutions for uses exclusively related to the administration of the program. I understand that this authorization will remain in effect until I submit a new request for a change or cancellation.
I understand that my Commuter Benefits transit account balance and information will be maintained by ECBS and are accessible online at www.commuterbenefitsnyc.com or by calling ECBS Customer Service at (833) 584-8109.

Employee Signature _____ **DATE** MONTH ☐☐ DAY ☐☐ YEAR ☐☐☐☐

AGENCY PAYROLL SECTION

Payroll #	**Personal information updated in NYCAPS (check all that apply):** ☐ **Mailing Address** ☐ **Email Address** ☐ **Phone Number**	**PI ENTRY DATE** MONTH ☐☐ DAY ☐☐ YEAR ☐☐☐☐

I certify that the above data was entered into PI:

Prepared By (Please Print)	**Signature**	**Date**

(04/2019)