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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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

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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

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

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

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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
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:** _____

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

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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.

IMPORTANT: EMPLOYEES HIRED ON OR AFTER OCTOBER 1, 2022 will only be eligible to enroll in the EmblemHealth HIP HMO Preferred Plan.

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.

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 ___/___/___

Effective Date of Hire ___/___/___

_____
Job Title and Code

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 ten 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