Health Benefits Program

Employee Application/Change Form

www.nyc.gov/olr

Centralized NYCAPS agency/H+H employees ***MUST*** complete the Health Benefits Application through their employee self service.
Non-Centralized agency employees ***MUST*** complete this form and return it to their agency Human Resources Office.
Domestic Partner Changes - Return form to: Health Benefits Program 22 Cortlandt Street, 12th Floor, New York, NY 10007

Please print all information clearly using a black or blue ballpoint pen. See reverse for instructions.

REASON(S) FOR SUBMISSION (Check one or more boxes. Enter change date, if appropriate)

A.
- ❑ New Enrollment
- ☐ Reinstatement*
- ☐ Add Optional Benefits*
- ☐ Drop Optional Benefits*
- ☐ Waive Benefits*
- ❑ Buy-Out Waiver Program
  COMPLETE SECTIONS D, E, F & H
  YOU MUST ALSO COMPLETE THE MSC BUY-OUT WAIVER FORM

*Please indicate Effective Date: _____/_____/_____

B. Change of (see page 3 for required documentation):
- ❑ Spouse/Domestic Partner: ❑Add ☐Drop
  Effective Date: _____/_____/_____
- ☐ Dependent Child(ren): ☐Add ☐Drop
  Effective Date: _____/_____/_____
- ☐ Change of Name - Former Name:*
  _____
  *Attach legal documents

C. Transfer of Health Plan and/or Optional Rider Benefits Based on:
- ☐ Transfer Period
- ☐ Move Into/Out of Health Plan Area
  Effective Date: _____/_____/_____
- ☐ HIP HMO Exemption
- ☐ Transfer after HIP HMO Mandate at Enrollment

D. EMPLOYEE INFORMATION

Last Name:	First Name:	M.I.:	Social Security Number: - -	Employee Payroll ID#

Home Address:	Apt.:

City:	State:	Zip Code:	Country (if outside the U.S.):

Date of Birth: / /	Gender: ☐M ☐F ☐N ☐O	Work - Telephone Number: ( ) -	Mobile\Home - Telephone Number: ( ) -	E-mail Address:

Marital Status: ☐Single ☐Married ☐Divorced ☐Domestic Partnership ☐Widowed	Date of Event (MM/DD/YY) / /	Agency/Institution (Name of agency not division:	Union or Welfare Fund:

Name of current City Health Plan:	Name of new City Health Plan (if changing)

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: / /

Gender: ☐M ☐F ☐N ☐O

Does spouse/domestic partner have City coverage?: ☐Yes ☐No

☐Employed (**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 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 are eligible for individual coverage ***only***. Contact your benefits office for information about family coverage.)

Dependent's Last Name:	Dependent's First Name:	Date of Birth:	Social Security Number:	Gender: M/F/N/O	ADD COVERAGE	DROP COVERAGE	PERMANENTLY DISABLED
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

G. HEALTH PLAN ELECTION (Please print clearly)

Newly hired employees on or after October 1, 2022 for 365 days: ☐HIP HMO Basic ☐HIP HMO Rider

FULL NAME OF HEALTH PLAN SELECTED: _____

Optional Rider Benefits? (Check "Yes" or "No" for optional rider benefits. If no box is checked, it will be presumed that you do not want optional rider benefits.) ☐Yes ☐No

H. 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. I understand that if I do not complete the MSC Form, I will not be eligible to receive payments. (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 the amount required, if any, through the City Health Benefits Program.

Furthermore, I agree that my 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.

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 Signature:	Date:

J. FOR COMPLETION BY AGENCY PAYROLL OR PERSONNEL OFFICE ONLY

I certify that the above employee 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:	Status: ☐Full-Time ☐Part-Time ☐Permanent ☐Provisional	Pay Period: ☐Weekly ☐Bi-Weekly ☐Monthly ☐Semi-Monthly	Appointment Date:	Effective Date of Coverage:

Certifying Signature:	Date:	Telephone Number:

Instructions for Completing the Health Benefits Application/Change Form

Please refer to the Health Benefits Program Summary of Plan Description (SPD) located on the Program website at nyc.gov/hbp for benefits information and if you should be using Employee Self Service (ESS) or completing this form in order to enroll in or change your health benefits.

Gender Categories:

M - Male/Man
F - Female/Woman
N - Non-binary (Not female/woman or male/man)
0 - Choose not to disclose

Section A: Please complete this section indicating the reason for your submission.

Section B: Please complete this section if you are adding a spouse, domestic partner or dependent child(ren). Refer to the Dependent Eligibility Required Documentation on page 3 of this form or on our website, at nyc.gov/hbp, for a list of all dependent eligibility documentation requirements for health benefits coverage for dependents.

If you are dropping a spouse, domestic partner or dependent child(ren) please submit appropriate documentation, e.g., death certificate, divorce decree, termination of domestic partnership or court order.

If changing your name, please indicate your former name and provide documentation of name change.

Section C: Check Transfer Period if the change you are requesting (such as Adding Optional Benefits or Changing Plans) is being made during a Transfer Period.

Check Permanent Move Into/Out of Health Plan Area if you are requesting to change plans as a result of either moving out of the service area of your current plan, or if you are moving into the service area of another plan.

Check HIP HMO Exemption if you have submitted a HIP HMO Opt-Out Request Form and the request was approved by EmblemHealth. Attach a copy of the approved form to this application.

Check Transfer after HIP HMO Mandatory Enrollment if you wish to enroll in a new health plan after the 365-day mandatory enrollment period is satisfied.

Section D: Please complete this section with the employee's information ***only***.

Section E: If you are married or have a domestic partner, this section must be completed only if you are covering your spouse/domestic partner.

If your spouse/domestic partner is enrolled in health plan other than your City coverage or Medicare, you must indicate so.

If your domestic partner is enrolled in Medicare Parts A & B, you must attach a photocopy of his/her Medicare card.

Domestic Partner Taxation: You should be aware that, under IRS rulings, if your domestic partner is not a 'dependent', within the meaning of the Internal Revenue Code, the amount paid by an employer attributable to coverage of a domestic partner is treated as part of the participant's gross income for Federal tax purposes. Consequently, unless you have indicated and provided proof to the Health Benefits Program (e.g. a copy of a recent tax return) that your domestic partner is your dependent; the value of this benefit must be included as income in your Federal tax return for the applicable year. State and local tax treatment of the amount in question will vary among jurisdictions. You should consult the applicable laws and/or a tax professional to ascertain how the amount should be treated in your case.

Section F: List **ALL** eligible dependent children to be covered.

Section G: Write the complete name of your current health plan or the plan you are selecting (see page 3 of this form for a list of health plans). If you do not make an optional rider selection, you will be given basic coverage only.

Section H: This section is for employees only who wish to participate in the Buy-Out Waiver Program. Remember to date your form. CUNY Adjunct employees are not eligible for the Buy-Out Wavier Program.

Section I: Your signature is required in this section to enroll or effect the changes requested on this Application/Change Form.

Section J: Your payroll/personnel office must complete this section.

See top, right-hand corner of reverse side for instructions on submitting this Application/Change Form.

Retain a copy for your records.

Dependent Eligibility Required Documentation

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

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Health Plans Available to
Employees and their Dependents

Aetna EPO
Cigna HealthCare
DC 37 Med-Team (DC 37 members only)
Empire EPO
Empire Blue Access Gated EPO
GHI-CBP/Empire BlueCross BlueShield
GHI HMO
HIP HMO
HIP Prime POS
MetroPlus Gold
Vytra Health Plans

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

Adjunct Enrollment Form

PSC-CUNY Welfare Fund
P.O. Box 280278
Brooklyn, NY 11228
Office: 212-354-5230
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

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.

Effective Date of Coverage: ___/___/___

Effective Date of Hire: ___/___/___

Earliest CUNY Hire Date: ___/___/___

_____
HR Signature - College 1 Print Name Date

_____
HR Signature - College 2 Print Name Date

[PSC-CUNY Welfare Fund Use Only] [Alpha]

_____ _____
Date Received Authorization Initials Date

Adjunct Health Insurance Verification Form

University Benefits Office City University of New York
555 West 57th Street - 11th Floor
New York, NY 10019
646-664-3401 Office, 646-664-3418 Facsimile, universitybenefitsadjuncts@cuny.edu

Employee

Last Name:_____ First Name: _____

StreetAddress: _____

City: _____ State:_____ Zip Code: _____

Marital Status: ☐Single ☐Married ☐Domestic Partner (circle **one** only)

CUNY Email Address: _____ Personal Email Address: _____

Day Phone Number: _____ Home Phone Number: _____

College # 1:_____Department: _____
☐ Teaching ☐ Non Teaching

College # 2:_____Department: _____
☐ Teaching ☐ Non Teaching

CUNYfirst Empl ID: _____ Semester: _____ 20_____

A certification must be submitted to the University Benefit Office every semester in order to maintain eligibility for Adjunct Health Insurance coverage. Below please check one item as it relates to your current status. After identifying your eligibility please sign and date.

☐ I do not have access to nor am I covered by other primary health insurance from any other source, including but not limited to other employment, my spouse/domestic partner's employment, Medicare (Part B) or the New York State Health Insurance Program (NYSHIP).

☐ I am now enrolled and covered by other primary health insurance from another source, including but not limited to other employment, my spouse/domestic partner's employment or the New York State Health Insurance Program (NYSHIP). My coverage is effective_____/_____/_____(mm/dd/yy).

Attestation: I hereby attest to the current eligibility status in the Adjunct Health Insurance Program as indicated above. I understand that it is my responsibility to contact my college Benefits Officer if, I will no longer be eligible for health insurance coverage and will be responsible for all medical expenses incurred. In the event that coverage terminates I may elect continuation of benefits at my own expense under COBRA. I understand that if I begin employment at a different campus, it is my responsibility to notify my current college Benefits Officer or my coverage may be terminated.

_____ _____

(Employee Signature) (Date)

Adjunct Health Insurance Certification Form

Please see reverse side for instructions

University Benefits Office
City University of New York
555 West 57th Street - 11th Floor
New York, NY 10019

CUNYfirst Empl ID: _____ Semester: _____ 20_____

Employee

Last Name: _____ First Name: _____

Street Address: _____

_____

City: _____ State: _____ Zip Code: _____

Marital Status: ☐ Single ☐ Married/Domestic Partner

If you are married, you must provide information on your spouse, regardless of whether you elect family coverage.

CUNY Email Address: _____ Personal Email Address: _____

Day Phone Number: _____ Home Phone Number: _____

Eligibility Qualifications

College # 1: _____ ☐ Teaching ☐ Non Teaching _____ _____

College Department Hours Benefit Officer Initials

College # 2: _____ ☐ Teaching ☐ Non Teaching _____ _____

College Department Hours Benefit Officer Initials

Spouse/Domestic Partner Information

Legal Relationship ☐ Spouse ☐ Domestic Partner

If you are married, you must provide information on your spouse, regardless of whether you elect family coverage.

Last Name: _____ First Name: _____

Spouse's Employer: _____

Spouse's Health Insurance: _____

Attestation: I hereby attest that I have met the current eligibility requirements as outlined in the Adjunct Health Insurance Procedures. I further certify that I am not covered by nor eligible for other primary health insurance from any other source, including but not limited to other employment, my spouse/domestic partner's employment or the New York State Health Insurance Program (NYSHIP). A certification must be submitted to the University every semester in order to maintain my eligibility for Adjunct Health Insurance coverage. Furthermore, I understand that it is my responsibility to contact my college Benefits Office if my hours fall below the required semester hours, as I will no longer be eligible for health insurance coverage and will be responsible for all healthcare costs incurred, unless I elect benefit continuation at my own expense under COBRA. I understand that I will make recurring payments through my bank account for health insurance coverage if applicable. I understand that if I go to a different school, it is my responsibility to notify my current college Benefits Officer or my coverage may be discontinued.

_____ _____

(Employee Signature) (Date)

Benefits Officer Verification

I hereby attest that the two-semester requirement has been met in accordance with the rules of the Collective Bargaining Agreement and that the hours and employment information is accurate for the semester indicated. The University Benefits Office at the current school, shall be apprised of all relevant changes to the employee's schedule which will impact eligibility for health insurance.

_____ _____ _____

Benefits Officer College 1 Date

_____ _____ _____

Benefits Officer College 2 Date

Adjunct Health Insurance Certification Form Instructions

The Adjunct Health Insurance Certification Form is required for processing your new health insurance coverage with the New York City Health Benefits Program. Please complete this form and submit to your college Benefits Officer, along with the Domestic Partner registration information or your Marriage/Civil Union Certificate, if applicable. (Please note: These documents are required for submission whether or not you intend to add your spouse/domestic partner to your coverage.)

1. Fill in your CUNYfirst Empl ID and Semester/Year for which you are applying for benefits.
2 Complete all fields within the "Employee" section with all appropriate information.
3. In the "Eligibility Qualification" section, your college Benefits Officer will certify the amount of teaching or non-teaching hours you work per week and initial in the space provided. PLEASE NOTE: If you are working at more than one campus to meet eligibility requirements, you must have the Benefits Officer from each college complete this section.
4. If you are married or have a domestic partner, the "Spouse/Domestic Partner" section must be completed whether or not you intend to add your spouse/domestic partner to your coverage. If your spouse/domestic partner is enrolled in a health plan other than your New York City Health Benefits Program coverage, you must indicate this information.
5. Please read the "Attestation" statement and sign your full name and date in the spaces provided.
6. The last section of this document is to be completed by the college Benefits Officer(s) who signs the "Eligibility Qualification" section. The last college Benefits Officer to sign the form, will forward this form and all other required enrollment paperwork to the University Benefits Officer.

Along with this form, please include your Domestic Partner registration information or Marriage/ Civil Union Certificate if applicable. Please also submit your Employee Health Benefits Application, Adjunct Recurring Payment Election Form (if applicable), Adjunct PSC-CUNY Enrollment Form, HIPAA Certificate and all other supporting documentation (i.e., Age 26 Young Adult Paperwork, Birth Certificate(s) for child(ren), etc.) to the last college Benefits Officer who signs this form.

Adjunct Recurring Payment Election Form

Please see reverse side for instructions

University Benefits Office
City University of New York
555 West 57th Street - 11th Floor
New York, NY 10019

CUNYfirst Empl ID: _____

Full Name: _____ College 1: _____
(Your Name as it appears on Bank Statements)

Personal Email: _____ College 2: _____

Banking Institution: _____ Routing Number: _____

- ◯ Checking Account (Attach Voided Check)
- ◯ Savings Account (Bank Signature Required)

Account Number: _____

Amount to be deducted monthly: _____

For savings accounts, and checking accounts without a voided check:
As a representative of the above named financial institution, I certify that this institution is ACH capable and agree that payments can be remitted from the account shown above.

_____ _____ _____
(Bank Rep's Printed Name) (Bank Rep's Signature) (Bank Rep's Telephone Number)

Employee/Joint Account Holders Certification: I certify that I have read and understand this form. By signing this form, I authorize my health insurance costs to be deducted from the account listed on this form. The joint account holder(s) for the account listed, if any, must sign on the corresponding line(s) for additional account holder(s).

Employee Signature: _____ Date: _____

Joint Account Holder: _____ Date: _____

Joint Account Holder: _____ Date: _____

By signing below, I certify that I permit the City University of New York to electronically withdraw funds from the above mentioned account to cover the expenses of my health insurance premiums, if any, based on the Adjunct Health Insurance Rate Sheet. I fully understand that the funds will be deducted from my account on a monthly basis on the first business day of the month preceding the period of coverage for which I am paying or the next possible administratively feasible date. I understand and agree that I am responsible for any fees associated with transactions due to insufficient funds in my account. I authorize the modification of deductions from my account due to future changes in expenses, including but not limited to premium rate and administrative fee changes, changes to my insurance made by me during the open enrollment period, and family status changes, in order to keep my health insurance current.

I, _____ , agree to the terms above, and I am fully aware that failure to remit payment according to these terms may result in the termination of my health insurance coverage.

_____ _____
(Employee Signature) (Date)

Adjunct Recurring Payment Election Form Instructions

This form should be completed by eligible Adjunct faculty members who are enrolling in a health plan for which premiums are required to be paid. This form, along with all the other required documents and forms to enroll in the New York City Health Benefits Program and the PSC/CUNY Welfare Fund Supplemental Benefits must be completed and submitted to your college Benefits Officer. If you are electing to have funds deducted from your checking account, you will need to include a voided check with this form. If you are electing to have funds deducted from your savings account, or a checking account for which you do not have a voided check, you are required to obtain a bank representative's signature in the space provided on this form. Please carefully follow the instructions below to complete this form.

1. Enter your CUNYfirst Empl ID and the Semester/Year for which you are applying for benefits in the spaces provided at the top of the form.
2. Enter your full name as it appears on your bank statements in the space provided for "Full Name".
3. Enter the name of the college(s) at which you are employed in the space(s) provided.
4. Enter your personal email address in the space provided.
5. Enter the name of your bank in the space provided for "Banking Institution".
6. Enter the nine digit Routing Number for your bank as it appears at the bottom of your personal checks or savings account deposit slips.
7. Fill in the radio button that corresponds with the account from which you wish to have your payments deducted.
8. Enter the Account Number from which you wish to have your monthly premium remittance withdrawn in the space labeled "Account Number".
9. Enter premium amount to be paid monthly in the space provided. Please refer to the rate sheet on the UBO website. http://www.cuny.edu/benefits
10. If the account listed is a joint account, you and the joint account holder(s) must complete the Employee/Joint Account Holders Certification section by signing and dating the form in the spaces provided.
11. Carefully read the terms of automatic recurring payments.
12. Print your name in the space provided.
13. Sign and date the form at the bottom of the document in the space provided.

Adjunct Family Enrollment Supplement

PSC-CUNY Welfare Fund

P.O. Box 280278
Brooklyn, NY 11228
Office: 212-354-5230 www.psccunywf.org

A copy of your NYC Health Benefits Enrollment Form must be attached.
A copy of your PSCCUNY Welfare Fund Enrollment Form must be attached.
Enrollment in Family Coverage through NYC Health Benefits is Required

Enrollee

NY State / NY City ID # _____

Last Name _____ **First Name** _____

Social Security Number - -

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

I hereby certify that all information I have provided on this Enrollment Form is true and accurate.
I further agree to pay the posted premium for family coverage to the PSC-CUNY Welfare Fund

Member Signature _____ **Date** _____

Effective Rate 1/1/2023

WF Benefits with Guardian Dental	**$ 218 per month**
WF Benefits with Delta Dental	**$ 143 per month**

[College HR Office Use Only]

The individual named herein is eligible for family coverage under the PSC-CUNY Welfare Fund and
All required documents have been presented to authorize coverage of individuals listed herein.

Signature	Name	Title/ Campus	Date Signed
			/ /

[PSC-CUNY Welfare Fund Use Only]

Status _____ Authorization _____