Instructions for completing a Health Benefits Application
(For Employees)
(Please print all information clearly using a black or blue ballpoint pen)

Check the EMPLOYEE box at the top of the form.

Sections A, B & C: Check off the reason for submission of this form.

Employees may only transfer plans during a *transfer period* or upon a change of residence *outside/inside of the service area of the health plan*. Documentation verifying *spouse or domestic partner and dependent children* must be submitted for all new enrollments and addition of dependents. Obtain a domestic partner instruction sheet from your personnel office or the Office of Labor Relations if you wish to include a domestic partner on your medical coverage.

If you are adding or dropping a dependent or changing plans, this form should be submitted within 31 days of the qualifying event.

Section D: If you are enrolled in a health plan other than your City coverage, you must indicate so and include the name and policy number of the plan.

Section E: If you are married or have a domestic partner, this section must be completed whether or not you are covering your spouse/ domestic partner. If your spouse/domestic partner is enrolled in a health plan other than your City coverage, you must indicate so including the name and policy number of the other plan.

Section F: List ALL dependents to be covered. You must indicate yes/no if a dependent is a full-time student or if a dependent is permanently disabled.

Section G: Write the complete name of the health plan you are selecting or your current plan (see back of this sheet) if you are adding or dropping a dependent or optional rider. If you do not make an optional rider selection, you will be given basic coverage only.

Section I: Complete this section only if you are electing the Waiver Buy Out. A Medical Spending Conversion application must also be completed. Contact your personnel/payroll office for information about the Waiver Buy Out Program.

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

Employees: Return this application to your Agency Benefits Representative, Personnel or Payroll Officer.

Instructions for completing a Health Benefits Application
(For Retirees)
(Please print all information clearly using a black or blue ballpoint pen)

Check the RETIREE box at the top of the form.

Section A: If you are a NEW retiree, you should only select from the following: *Retirement, Disability Retirement, Accident Disability Retirement, Deferred Retirement or Waive Benefits*. If you are already covered as a retiree, you should only select from the following: *Drop/Add Optional Benefits, Waive Benefits* (if you wish to cancel your City coverage) and *Reinstatement* (if you are requesting to reinstate your City coverage after having previously Waived coverage).

Section B: Check *Transfer Period* if the change you are requesting is being made during a Transfer Period (such as Adding Optional Benefits or Changing Plans). 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 *Retiree Once in a Lifetime* if you are requesting to change plans or add optional benefits anytime other than a transfer period.

Section C: Check *Spouse Information* (Add/Drop) if you are adding or dropping a spouse. If your spouse/domestic partner is deceased, you must attach a copy of a death certificate. If you are dropping your spouse as a result of a divorce, you must attach a copy of the divorce decree. If you are adding a spouse, you must attach a copy of the marriage certificate or submit domestic partner documentation if adding a domestic partner. Check *Dependent (Children)* (Add/Drop) if you are adding or dropping a dependent child. If you are adding a dependent child, you must attach a copy of either the birth certificate, or documents proving guardianship or adoption.

Section D: If you are enrolled in Medicare Parts A&B, you must attach a photocopy of your Medicare card. If you are enrolled in another health plan other than your City coverage or Medicare, you must indicate so including the name and policy number of the plan.

Section E: If you are married or have a domestic partner, this section must be completed whether or not 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 including the name and policy number of the plan. If your spouse/domestic partner is enrolled in Medicare Parts A&B, you must attach a photocopy of his/her Medicare card.

Section F: List ALL dependents to be covered. You must indicate yes/no if a dependent is a full-time student. If a dependent is permanently disabled, and on Medicare, you must attach a photocopy of his/her Medicare card.

Section G: Write the complete name of your current health plan or the plan you are selecting (see back of sheet). If you do not make an optional rider selection, you will be given basic coverage only.

Section H: This is the only section in which you are to sign the form. Remember to date your form.

Section J: If you are a NEW retiree (even if you are waiving City coverage), your payroll/personnel office must complete this section.

Retirees: Return this application to: City of New York
Health Benefits Program
40 Rector Street – 3rd Floor
New York, New York 10006

Health Plans Available to Employees, Non-Medicare Retirees and their Dependents

Aetna U.S. Healthcare HMO

Aetna U.S. Healthcare Quality Point of Service

CIGNA HealthCare

DC 37 Med-Team/Choice (DC 37 members Only)

Empire HMO

Empire EPO

GHI-CBP/Empire Blue Cross Blue Shield

GHI HMO

HIP Prime HMO

HIP Prime POS

MetroPlus Health Plan (HHC Employees and Non-Medicare Retirees Only)

PHS Health Plans

Vytra Health Plans

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the 2001 Summary Program Description booklet for service area restrictions or call the health plan directly.

Health Plans Available to Medicare Eligible Retirees and their Dependents

Aetna U.S. Healthcare Golden Medicare 5 Plan*

AvMed Medicare Plan*

BlueChoice Senior Plan*

Blue Cross Blue Shield of Florida Health Options, Inc.*

CIGNA HealthCare for Seniors*

DC 37 Med-Team Medicare Supplement
(DC 37 members Only)

Elderplan, Inc.*

Empire Medicare Supplement

GHI/Empire Blue Cross Blue Shield Senior Care

GHI HMO

HIP VIP Premier Medicare Plan*

Oxford Medicare Advantage*

PHS Health Plans SmartChoice*

PHS MedPrime

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the 2001 Summary Program Description booklet for service area restrictions or call the health plan directly.

***Medicare eligible retirees who wish to enroll in these plans must enroll DIRECTLY with the health plan. Please verify with the health plan of your choice whether or not you reside in its service area. Do not use this form for enrollment in these plans.**

This form can be filled out online. Once completed, print the document and sign where appropriate. These instructions will not appear on the print out.

Applicant MUST check one:

☐ **EMPLOYEE**
☐ **RETIREE**

HEALTH BENEFITS APPLICATION

CITY OF NEW YORK HEALTH BENEFITS PROGRAM

REASON(S) FOR SUBMISSION (Check one or more boxes: enter change date if appropriate)

A.
- ☐ New Enrollment
- ☐ Reinstatement
- ☐ Transfer From Another Agency
- ☐ Retirement
- ☐ Disability Retirement
- ☐ Accident Disability Retirement
- ☐ Deferred Retirement
- ☐ Drop Optional Benefits
- ☐ Add Optional Benefits

Cancel Benefits: (Check one)
- ☐ Waive Benefits
- ☐ Buy-Out Waiver Program (Employees Only) (Complete Sections D, E, F & I only)
- ☐ Other

B. Transfer of Health Plan and/or Optional Benefits Based on:
- ☐ Transfer Period
- ☐ Permanent Move Into/Out of Health Plan Area
  Eff. Date: mo dy yr
- ☐ Retiree Once In A Lifetime
- ☐ Other

C. Change Of:
- ☐ Spouse/Domestic Partner Information — Date of Event mo dy yr: ☐ Add ☐ Drop
- ☐ Dependent Child(ren) — mo dy yr: ☐ Add ☐ Drop
- ☐ Change of Name - Former Name:
- ☐ Other

D. EMPLOYEE/RETIREE INFORMATION

Last Name | First Name | M.I. | Social Security Number | Tel. No. Work / Home

Home Address - Number and Street | Apt. No | Date of Birth | Sex ☐ Male ☐ Female

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

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership | Date of Event | Agency in which Employed or Retired From | Union or Welfare Fund | Name of Current City Health Plan

Are you the contract holder on a non-City group health plan? ☐ Yes ☐ No | If "yes" indicate name of plan | Policy, ID or Medicare Claim No | If Medicare, Part A- Eff. Date | If Medicare, Part B- Eff. Date

Retirement System (If Applicable) | Yrs. Cred. Svc. (Retirees Only) | Retirement Date | Pension Number (Retirees Only)

E. SPOUSE/DOMESTIC PARTNER INFORMATION

Last Name | First Name | M.I. | Social Security Number | Date of Birth

Is your spouse/partner: ☐ Employed (check below) ☐ Retired (check below) ☐ Not Employed ☐ NYC Agency ☐ Other | Name of Spouse/ Partner's Employer | Is spouse/partner to be covered by employee/retiree? **(Double City coverage not permitted)** ☐ Yes ☐ No

Does spouse/partner have Non-City group health plan? ☐ Yes ☐ No | If "yes" indicate name of plan | Policy, ID or Medicare Claim No. | ☐ Individual ☐ Family | Effective Date

Is employee/retiree covered by spouse/partner group health plan? ☐ Yes ☐ No | Effective Date | If Medicare, Part A - Eff. Date | If Medicare, Part B - Eff. Date

F. FAMILY INFORMATION (Attach a second form if necessary; dependents may not be covered under two NYC plans.)

List below all family members to be covered or dropped, including yourself. If your plan requires you to choose a specific Medical Group (HIP Plans) or Primary Care Physician (Other HMOs) you must indicate the name and number of the group or physician chosen.

Name (Indicate different last name if applicable)	Birth Date MO DY YR	Social Security Number	Sex M/F	Check if Applicable: Full-Time Student	Permanently Disabled	Drop Coverage	Name & Number of Medical Group or Primary Care Physician: Name	Number
EMPLOYEE/RETIREE LAST FIRST	mm / dd / yyyy			☐	☐	☐		
SPOUSE/PARTNER LAST FIRST				☐	☐	☐		
DEPENDENT CHILD LAST (IF DIFF) FIRST				☐	☐	☐		
DEPENDENT CHILD LAST (IF DIFF) FIRST				☐	☐	☐		

G. HEALTH PLAN REQUESTED

HEALTH PLAN NAME IN FULL: _____
Please Print

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

H. TO PARTICIPATE IN THE HEALTH BENEFITS PROGRAM - PLEASE SIGN AND DATE BELOW (PARTICIPANT MUST SIGN EITHER SECTION H OR I)

I certify that the above information is correct and I authorize the City to deduct from my salary/pension the amount required, if any, through the City Health Benefits Program. I understand that the City Program's benefits will be coordinated with those available through Medicare or any other source.

Furthermore, I agree that my periodic health plan deductions, if any, will be made on a pre-tax basis pursuant to the Internal Revenue Code Section 125. I understand that I have an option to decline this benefit, by obtaining a Medical Spending Conversion brochure and completing a Medical Spending Conversion Form, both of which are obtainable at my payroll office. (Section 125 does not apply to retirees.)

If I have checked the Waive Benefits box in Section A, I am choosing not to participate in the City Health Benefits Program at this time.

_____ _____
Employee /Retiree Signature Date

I. TO PARTICIPATE IN THE HEALTH BENEFITS BUY-OUT WAIVER PROGRAM - PLEASE SIGN AND DATE BELOW (*SIGN EITHER SECTION H OR I)*

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 not eligible.)

_____ _____
Employee Signature Date

J. FOR COMPLETION BY PAYROLL OR PERSONNEL ONLY

I certify that the above employee/retiree is eligible for the New York City Health Benefits Program (HBP) and that dependent documentation has been verified in accordance with HBP procedures.

I certify that the above employee is eligible for the Health Benefits Buy-Out Waiver Program and I have reviewed and processed the Medical Spending Conversion Form and I attest that the employee meets the qualifications for this program.

_____ _____ _____
Certifying Signature Date Telephone Number

Agency Code	Title Code No.	Status ☐ Retired ☐ Full-Time ☐ Civil Service ☐ Part-Time ☐ Provisional	Appt Date/Ret. Date MO DY YR	Job Seq. No.	Present Health Code	Pay Period ☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Semi-Monthly	Effective Date MO DY YR	Waiver Effective Date MO DY YR