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 adding or dropping a spouse. If your spouse/domestic partner is enrolled in another health plan other than your City coverage or Medicare, you must indicate so including the name and policy number of the other plan.

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
A. New Enrollment
   Reinstatement
   Transfer From Another Agency
   Retirement
   Disability Retirement
   Accidental Disability Retirement
   Deferred Retirement

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
   Add  Drop
   Dependent Child(ren)
   Add  Drop
   Change of Name - Former Name:

D. EMPLOYEE/RETIREE INFORMATION
   Last Name  First Name  M.I.
   Social Security Number
   Tel. No.
   Work ( ) Home ( )
   City State Zip Code Country (if outside the U.S.)
   Home Address - Number and Street
   Home Telephone Number

E. SPOUSE/DOMESTIC PARTNER INFORMATION
   Last Name  First Name  M.I.
   Social Security Number
   Date of Birth
   Sex
   Employer and Address
   Home Telephone Number

F. FAMILY INFORMATION (Attach a second form if necessary; dependents may not be covered under two NYC plans.)
   Name
   Birth Date
   Social Security Number
   Sex
   Full-Time Student
   Permanently Disabled
   Drop Coverage

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 waive benefits 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 (NYP) and that dependent documentation has been verified in accordance with NYP 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.

Employee/Retiree Signature
Date

Certifying Signature
Date

Agency Code  Title Code No.
Status  Retired  Civil Service  Provisional
Full-Time  Part-Time
Applicant/Retiree  Date/Date
Job Seq. No.
Present Health Code
Pay Period
Weekly  Bi-Weekly  Semi-Monthly
Effective Date
MO  DY  YR
Maximum Effective Date
MO  DY  YR
Telephone Number

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

J. FOR COMPLETION BY PAYROLL OR PERSONNEL ONLY

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 waive benefits 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 (NYP) and that dependent documentation has been verified in accordance with NYP 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.

Employee/Retiree Signature
Date

Certifying Signature
Date

Agency Code  Title Code No.
Status  Retired  Civil Service  Provisional
Full-Time  Part-Time
Applicant/Retiree  Date/Date
Job Seq. No.
Present Health Code
Pay Period
Weekly  Bi-Weekly  Semi-Monthly
Effective Date
MO  DY  YR
Maximum Effective Date
MO  DY  YR
Telephone Number

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

J. FOR COMPLETION BY PAYROLL OR PERSONNEL ONLY

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 waive benefits 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 (NYP) and that dependent documentation has been verified in accordance with NYP 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.

Employee/Retiree Signature
Date

Certifying Signature
Date

Agency Code  Title Code No.
Status  Retired  Civil Service  Provisional
Full-Time  Part-Time
Applicant/Retiree  Date/Date
Job Seq. No.
Present Health Code
Pay Period
Weekly  Bi-Weekly  Semi-Monthly
Effective Date
MO  DY  YR
Maximum Effective Date
MO  DY  YR
Telephone Number

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