The City (	
New 2	York

## Health Benefits Program Application/Change Form

www.nyc.gov/olr

Employees<br/>Return Form to:Retirees (212) 513-0470<br/>Return Form to:For Domestic Partner<br/>Changes - Return Form to:Your Agency's<br/>Payroll or<br/>Personnel OfficeHealth Benefits Program<br/>40 Rector Street - 3rd Fl.<br/>New York, NY 10006<br/>FAX: (212) 306-7756Health Benefits Program<br/>40 Rector Street - 3rd Fl.<br/>New York, NY 10006<br/>Attn: Domestic Partner Unit

	Applicant MUST	check one:		PLOYEE				REMENT				ere previous	ly retired)	
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Here Address:       Apt:         OP:														
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Billuis         Mudane di Dornestio Patterstipi         /         /         Array           Name of Current City Heath Plan:         Ary vui Medicare card to this application.         Control Contrel Contrel Contrel Control Control Contrel Control Control Control				Date of Event (N	- 1M/dd/yy) A	Agency in wl	hich employe	- d or retired	from:		Union or We	elfare Fund:		
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Last Name:       If its Name:       M.1:       Social Security Number:       Date of Bith:         Is spoule/domestic partner:       City Agency Name       Image: City Agency Name<	Name of current City I	Health Plan:									to this appli	cation.		ATTACH COPY OF CARD
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Ind       If YES, please attach a copy of his/her Medicare card to this application.       Impact of the provide the provide index of the provide ind		City	Agency Na	ame:	-			-	<b>D</b> No	on-City Relat	ed			
FAULTH VINORMATION (Attach a second form if necessary, dependent may not be covered under two NVC Health Plans.)      Attach a copy of Medicare card if      disabled dependent indigent. Indicate if you are adding of dropping coverage by checking the appropriate box below.     The second dependent is Medicare eard if      disabled dependent is Medicare eard if      d		c partner have	Non-City	group health plan	?					Ū				ATTACH COPY OF CARD
Last Name       Prist Name       Date of Hith:       Oddard security Wontruer.       Sec.       COVERAGE       CO	List all eligible depend	ent children. I	ndicate if	you are adding or	dropping co	overage by o	checking the	appropriate	box bel	ow.		*Attach		
Dependent       /       /       -	Last Na	ame:		First Nam	e:	Dat	te of Birth:	Socia	al Secur	ity Number:	Sex:			
Dependent       /       /       -	Depend	dent				/	/		-	-				
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	Depend	dent				/	/ /		-	-				
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)       Investigation 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 1 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 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 and I have reviewed and processed the Medical Spending Conversion 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.         Participate Into BY PAYROLL OR PERSONNEL OFFICE ONLY       Imate Provisional <td>Depen</td> <td>dent</td> <td></td> <td></td> <td></td> <td>1</td> <td>/ /</td> <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td></td> <td></td>	Depen	dent				1	/ /		-	-				
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.)       Image:					)									
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: Date:  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 payrolol fibre. (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:  Date					er. If no box	is checked,	, it will be pre	sumed that	you do	not want op	tional benef	its.) 🛛 Yes	□No	
Image: Control of the state of the stat	I wish to participate in	n the Health Be	enefits Bu	y-Out Waiver Prog	jram. I have	e read the M	ledical Spend	ling Conver	rsion He	alth Benefit	s Buy-Out V			
	. , ,											Date:		
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: <ul> <li>Part-Time</li> <li>Provisional</li> <li>/</li> <li>Years of Credited Service:</li> <li>City Start Date:</li> <li>/</li> <li>/</li> <li>/</li> </ul> Retirement Date:     Pension Number:	I certify that the above I understand that the Furthermore, I agree decline this benefit, by If I have checked the	e information is City Program's that my periodi / obtaining a M Waive Benefits	s correct a benefits ic health p ledical Sp	and I authorize the will be coordinated plan deductions, if pending Conversio	City to ded I with those any, will be n Form, bot	uct from my available th made on a th of which a	salary/pension sough Medic pre-tax basis are obtainable	on the amo are or any o pursuant to at my pay	unt requ other so o the Int roll offic	iired, if any, urce. ernal Rever e. (Section	through the nue Code 12 125 does no	5. I understar apply to retin	nd that I have	
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: <ul> <li>Part-Time</li> <li>Provisional</li> <li>/</li> <li>Years of Credited Service:</li> <li>City Start Date:</li> <li>/</li> <li>/</li> <li>/</li> </ul> Retirement Date:     Pension Number:	J. FOR COMPLE		AYROLL	OR PERSONN		CE ONLY								
Agency Code:       Title Code No.:       Status:       Appointment/Retirement Date:       Pay Period:       Effective Date of Coverage: <ul> <li>Part-Time</li> <li>Provisional</li> <li>/</li> <li>Years of Credited Service:</li> <li>City Start Date:</li> <li>/</li> <li>/</li> <li>/</li> <li>/</li> </ul> Effective Date of Coverage:           Pay Period:         Weekly         Monthly           Bi-Weekly         Semi-Monthly           /         /         /           Retirement System (For Retiring Employees):         Years of Credited Service:         City Start Date:         Period:         Pension Number:	procedures. I certify	that the above	employe	e is eligible for the	Health Ber	nefits Buy-O	ut Waiver Pro							
Retirement System (For Retiring Employees):       Years of Credited Service:       City Start Date:       Retirement Date:       Pension Number:         /       /       /       /       /       /       /       /			Status:	Time D Pern	Ananent			Date:	U We	ekly	-		e Date of Co	overage:
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## Instructions for Completing a Health Benefits Application/Change Form

**Section A:** If you are a NEW retiree, you should only select from the following: Retirement, Disability Retirement, Accident Disability 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 Spouse/Domestic Partner Information (Add/Drop) if you are adding or dropping a spouse/domestic partner.

If your spouse/domestic partner is deceased, you must attach a copy of the 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, domestic partner or dependent child(ren) please refer to the SPD or the Dependent Eligibility Required Documentation instructions on our Web site, at nyc.gov/hbp, for a list of all dependent eligibility documentation requirements for health benefits coverage for dependents.

Check Dependent Child(ren) Add or 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.

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 Retiree Once in a Lifetime if you are requesting to change plans or add optional benefits anytime other than a transfer period.

- **Section D:** If you are enrolled in Medicare Parts A & B, you must attach a photocopy of your Medicare card.
- **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 spouse/domestic partner is enrolled in Medicare Parts A & B, you must attach a photocopy of his/her Medicare card.

- Section F: List ALL eligible dependent children to be covered. If a dependent child is permanently disabled, and on Medicare, you must attach a photocopy of his/her Medicare card. (CUNY ADJUNCT EMPLOYEES: City rates apply for Individual coverage ONLY. Contact your Benefits Office for information about additional cost for Family coverage.)
- **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 section is for employees only who wish to participate in the Buy-Out Waiver Program. Remember to date your form. Retirees, Line of Duty Survivors and 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:** If you are a NEW retiree (even if you are waiving City coverage), 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.

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

Aetna EPO Cigna HealthCare DC 37 Med-Team (DC 37 members only) Empire EPO Empire HMO GHI-CBP/Empire BlueCross BlueShield GHI HMO HIP Prime 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.

## Health Plans Available to Medicare-Eligible Retirees and their Dependents

Aetna Medicare PPO ESA Plan\* AvMed Medicare HMO\* (Florida only) Cigna HealthSpring Preferred with Rx (HMO)\* (Arizona only) DC 37 Med-Team Senior Plan (DC 37 Members Only) Elderplan\* Empire Medicare Related Coverage Empire MediBlue HMO\* GHI/Empire BlueCross BlueShield Senior Care GHI HMO Medicare Senior Supplement HIP VIP Premier (HMO) Medicare Plan\* Humana Gold Plus (certain counties in Florida)\* UnitedHealthcare Group Medicare Advantage Plan\*

**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.

\* 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.