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
☐ Retirement
☐ Disability Retirement
☐ Accident Disability 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
mo dy yr
Eff. Date: / /
☐ Retiree Once-in-A-Lifetime
☐ Other _____

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

D. EMPLOYEE/RETIREE INFORMATION

Last Name	First Name	M.I.	Social Security Number	Tel.No: Home: ( ) Cell: ( )
			_ _	

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	Medicare Claim No.	☐ If Medicare Part A - Effective Date / / ☐ If Medicare Part B - Effective Date / /	Attach copy of card

Retirement System (Retirees Only)	Yrs. Credited Service	City Start Date	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/domestic partner: ☐employed ☐retired ☐not employed
☐ City Agency Name: _____ ☐ Non-City related

Is spouse/partner to be covered by employee/retiree's health plan?
(Double City coverage is not permitted) ☐ Yes ☐ No

Does spouse/partner have Non-City group health plan? ☐Yes ☐No	Medicare Claim No.:	☐ If Medicare Part A - Effective Date / / ☐ If Medicare Part B - Effective Date / /	Attach copy of card

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

(List all eligible dependents to be covered by your health plan)

		Birth Date MO DY YR	Social Security Number	Sex M/F	Check if Applicable: Full-Time Student	Permanently Disabled	Drop Coverage
Spouse/Domestic Partner Last Name	First	/ /	- -				
Dependent Last Name	First	/ /	- -				
Dependent Last Name	First	/ /	- -				
Dependent Last Name	First	/ /	- -				

G. HEALTH PLAN REQUESTED

HEALTH PLAN NAME IN FULL (Please Print Clearly): _____

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. TO PARTICIPATE IN THE HEALTH BENEFITS PROGRAM - PLEASE SIGN & 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 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 _____

I. TO PARTICIPATE IN THE HEALTH BENEFITS BUY-OUT WAIVER PROGRAM - SIGN & DATE BELOW (Participant must sign either Section H or I)

I wish to partipcate 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 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 Form and I attest that the employee meets the qualifications for this Program.

✍ Certifying Signature _____ Date _____ Telephone Number _____

Agency Code	Title Code No	Status	Appointment Date/Ret. Date	Pay Period	Effective Date of Coverage
		☐ FT ☐ Civil Service ☐ PT ☐ Provisional	MO DY YR	☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Semi-Monthly	MO DY YR

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

Aetna HMO
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 Health Plan (HHC Employees and Non-Medicare Retirees only)
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 Golden Medicare 10
Avmed Medicare Plan
Cigna HealthCare for Seniors* (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 Medicare Plan*
Humana Gold Plus (certain counties in Florida)*
SecureHorizons by UnitedHealthCare*

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.

Instructions for Completing a Health Benefits Application for Retirees

(Please print all information clearly using a black or blue ballpoint pen)

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/domestic partner. 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.

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. 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 I: (Retirees not eligible) Buy-Out Wavier Program.

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