Health Benefits Program
Application/Change Form

www.nyc.gov/olr

Employees Return Form to:	Retirees (212) 513-0470 Return Form to:	For Domestic Partner Changes - Return Form to:
Your Agency's Payroll or Personnel Office	**Please submit this form electronically to: https://nycemployeebenefits.leapfile.net**	

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

Applicant MUST check one: ❑ EMPLOYEE ❑ RETIREE ❑ RETURN TO RETIREMENT (Check this box if you were previously retired) ❑ LINE OF DUTY SURVIVOR

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*
- ❑ Waive Benefits*

EMPLOYEES ONLY:
- ❑ Buy-Out Waiver Program
  COMPLETE SECTIONS D, E, F & H

*Please indicate Effective Date: _____/_____/_____

B. Change of:
- ❑ Spouse/Domestic Partner: ❑Add ❑Drop
  Effective Date: _____/_____/_____
- ❑ Dependent Child(ren): ❑Add ❑Drop
  Effective Date: _____/_____/_____
- ❑ Change of Name - Former Name:
  _____

C. Transfer of Health Plan and/or Optional/Benefit Based on:
- ❑ Transfer Period
- ❑ Move Into/Out of Health Plan Area
  Effective Date: _____/_____/_____
- ❑ Retiree Once-in-A-Lifetime
  Effective Date: _____/_____/_____

D. EMPLOYEE/RETIREE INFORMATION

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

Home Address:	Apt.:	Pension Number:

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

Date of Birth:	Sex:	Work - Telephone Number:	Mobile\Home - Telephone Number:	E-mail Address:
	❑M ❑F	( ) -	( ) -	

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 Medicare eligible: ❑Yes ❑No If YES, please attach a copy of your Medicare card to this application.	ATTACH COPY OF CARD

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:
			- -	/ /

Sex: ❑M ❑F	Is spouse/domestic partner: ❑Employed (**Double City coverage is not permitted**) ❑Retired (**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 spouse/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 EMPLOYEES: CITY RATES APPLY FOR INDIVIDUAL COVERAGE ***ONLY***. CONTACT YOUR BENEFITS OFFICE FOR INFORMATION ABOUT ADDITIONAL COST FOR FAMILY COVERAGE.)

*Attach a copy of Medicare card if disabled dependent is Medicare eligible.

Dependent's Last Name:	Dependent's First Name:	Date of Birth:	Social Security Number:	Sex: M/F	ADD COVERAGE	DROP COVERAGE	PERMANENTLY DISABLED*
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑

G. HEALTH PLAN REQUESTED (Please print clearly)

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)

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:

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/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:

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 Buy-Out Spending Form and I attest that the employee meets the qualifications for this Program.

Agency Code:	Title Code No.:	Status: ❑ Full-Time ❑ Part-Time ❑ Permanent ❑ Provisional	Appointment/Retirement Date: / /	Pay Period: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Semi-Monthly	Effective Date of Coverage: / /

Retirement System (For Retiring Employees):	Years of Credited Service:	City Start Date: / /	Retirement Date: / /	Pension Number:

Certifying Signature:	Date: / /	Telephone Number: ( ) -

Print Form | Clear Fields

Enrollment Form

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

Primary Telephone: (___) _____ Primary Email: _____

Dental

For more information visit: www.psccunywf.org

Guardian PPO ☐

DeltaCare USA HMO ☐ **Delta will assign you a Dentist. To change it, call Delta or go Online.*

Health Plan

	Basic	Rider	Waived	Stipend
_____	☐	☐	☐	☐

Waive ALL Benefits: Rx, Dental, Vision, Hearing Aid ☐

Member

I hereby certify that all of my personal information presented here is true and accurate.

_____
Signature Date

College

_____ Effective Date of Coverage: ___/___/___
CUNY Campus

Effective Date of Hire: ___/___/___

_____
Job Title and Code Earliest CUNY Hire Date: ___/___/___

If Classified Managerial check here ☐ _____
Previous College (if applicable)

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.

Benefits Officer _____ Date _____

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

_____ _____
Date Received Authorization Initials Date

Revised 9/2/22 RN

PSC-CUNY Welfare Fund Death Benefit Beneficiary Designation Card

Name of Employee (Last) (First) Middle Initial		
Social Security Number	Male ○ Female ◉	Date of Birth Mo. Day Yr.
Name of College:		
Date employed:		Job title
Primary Beneficiary Name	Telephone number	relation to me
Primary Beneficiary Address,		
Contingent Beneficiary Name	Telephone number	relation to me
Contingent Beneficiary Address,		
Date Signed Mo. Day Yr.	Signature of Employee	

Order of Payment and Division of Benefits. Unless otherwise provided:

(a) Payment at my death is to be made to a primary beneficiary if he/she is then living.

(b) Payment at my death is to be made to a contingent beneficiary if he/she is then living and there is no primary beneficiary then living.

(c) If all beneficiaries predecease me, the benefits will be payable to my estate.

The City University of New York
Information Regarding Pension System Membership

I. Full-Time Instructional Staff (Including Higher Education Officers, Teaching Faculty, Librarians, Registrar Series Employees, Counselors, Executive Compensation Program and Substitute titles):

All full-time Instructional Staff are eligible for membership in either the Optional Retirement Program (ORP), which refers to membership in TIAA-CREF and the Alternate Funding Vehicles after vesting, or the Teachers' Retirement System of the City of New York (TRS). In some cases, an employee who is already a member of the New York City Employees' Retirement System (NYCERS) and who is appointed to a full-time Instructional Staff position may retain membership in NYCERS as a "Transferred Contributor", thereby revoking his/her rights to join any other public pension plan in the future. Regardless of choice, pension membership, with the exception of Substitutes or Visiting Professor titles, is mandatory for all full-time Instructional Staff. ***Substitutes can join the ORP or TRS*** (unless they are Transferred Contributors of another public pension).

New Instructional Staff who are NYCERS members on a leave of absence from a civil service position must make an election to remain in NYCERS until they have relinquished their leave. The employee has thirty (30) days to: 1) elect to remain in NYCERS as a "Transferred Contributor" and must resign the underlying title; 2) transfer to TRS with no need to resign the underlying title; or 3) elect membership in the ORP with no need to resign the underlying title.

1) **Remain a NYCERS member,** you must resign your NYCERS-eligible position and complete a Transferred Contributor Affidavit (download from www.nycers.org). You must notify your Human Resource officer of your resignation in writing then send the affidavit, along with proof of resignation to your Benefits Officer. They will send verification of your resignation along with other documents to NYCERS. **Choosing "Transferred Contributor" status means that you will be renouncing any present or prospective benefit from any other New York City public employee retirement system.**

2) **Join TRS and then transfer your NYCERS membership,** complete a TRS membership application (download from www.trsnyc.org) and submit it to TRS. To transfer your NYCERS membership, complete NYCERS' Transfer Form #321 (download from www.nycers.org) and submit it to your Benefits Officer. **Please be advised that you are not required to resign your NYCERS eligible position if you choose this option.**

3) **Join ORP, if** you choose TIAA-CREF and are transferring from a NYCERS eligible tittle, there is no need to resign your underlying position.

Any member of NYCERS as long as they resign from NYCERS, who is eligible to elect membership in the ORP, may be able to retain rights to a NYCERS retirement benefit, even if normal vesting time frames have not been met, provided contributions to the pension system are not withdrawn.

By law, Instructional Staff participating in the ORP who are reclassified must remain a member of the TIAA-CREF pension system, unless there is a break in service. However, Instructional Staff enrolled in the ORP who transfer from full-time status to part-time status must remain in the ORP.

II. Full-Time Classified Staff:

All full-time Classified Staff are required to join the New York City Employees' Retirement System six months after gaining permanent status .(Those in provisional status may elect to join earlier) .Classified Managerial are also given the opportunity to join the ORP upon appointment to their position pursuant to the rules cited in section I.

My signature below indicates that I have read the information above and have consulted with my College Human Resources Office regarding any questions concerning my pension system options and rights.

Signature	Name (print)	Date	HR Office Verification

The information provided within this document is based upon currently available information and should not be considered the sole source of information regarding pension membership. In all cases, the provisions of governing laws, rules and regulations prevail.

The City University of New York

RETIREMENT PROGRAM ELECTION FORM
For Full-Time Staff / Civil Service Managers

This form is to be used for eligible employees of CUNY who are appointed, promoted, transferred or re-classified to an eligible Full-time Staff / Classified Managerial position. For those electing the Optional Retirement Program (ORP), this election form must be accompanied by proof of online enrollment with TIAA-CREF. **New employees who do not complete the election process within the statutory time frame noted in the attached information sheet are by law forced into membership with TRS or, if Classified Managerial, into NYCERS.**

Section 1: Personal Information

Name:_____ Last four digits of Social Security Number: _____

Home Address:_____

College:_____ Job Title:_____ Pension Member # (if any):_____

Section 2: Election of Retirement Program

Having received written notification of my retirement system options and having satisfied myself as to the desired retirement system available to me by or pursuant to law in connection with my employment by the City University of New York, I hereby make the following election in regard to my participation in the retirement system as specified below: (check one only)

1)_____ **The Optional Retirement Program (ORP) – For Instructional Staff Only (must enroll online).**
I have attached the TIAA-CREF Retirement Annuity Application.
a) *Visiting Professors- Have the option to join TIAA-CREF if they work at least 50% of a full-time schedule and have a pre-existing vested open account with the TIAA/CREF retirement system.*
b) *Substitute Titles –Have the option to join TIAA-CREF.*

2)_____ **Teachers' Retirement System of The City of New York – For Instructional Staff Only**
a) *Visiting Professors or Substitute Titles–Have the option to join TRS as of January 2004.*
b) *Non-Teaching Adjuncts – Have the option to join TRS as of February 2002.*
c) *If already a member of TRS as a "Transferred Contributor" through a former position in public service, you may elect to remain in TRS.**
d) *Visiting Professors can join TRS, if they have a current account open with TRS.*

3)_____ **The New York City Employees' Retirement System – Classified Managerial Only**
a) *If already a member of the NYCERS as a "Transferred Contributor" through a former position in public service, you may elect to remain in NYCERS.**

4)_____ **The Board of Education Retirement System*** (for current members only);

5)_____ I have been appointed to a **Substitute or Visiting** Professor title and opt not to join the ORP or TRS; therefore, I choose not to be a member of a pension system at this time.

Signature Name (Print) Date HR Office Verification

***Those participating as Transferred Contributors please check here** ☐

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION

Name of Policyholder: NYSUT Member Benefits Trust	Group Customer # 35370

Source Code (Office Use Only)

NYSUT DB 53162/53163/1001/53275-S
NYSUT PRD 53160/53161/1002/53275
UFT DB 53150/53151/1001/53276-S
UFT PRD 53148/53149/1002/53276
NYSUT DB RET 53156/53157/1003/53275-S
NYSUT PEN RET 53154/53155/1004/53275

YOUR ENROLLMENT INFORMATION

I am the: ☐ NYSUT Member ☐ Spouse/Domestic Partner[1]

Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Member Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Phone #	Email Address	
NYSUT Member Name (First, Middle, Last)	NYSUT ID #	☐ New Enrollment ☐ Change in Enrollment	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below. If you enroll for certain Contributory Insurance, a portion of your contributions for such insurance will be allocated to fund the premium for certain Noncontributory Insurance under the Policyholder's Group Insurance Program.

Term Life Insurance

☐ Term Life [1,2,3]

Enter a multiple of $5,000 $_____ up to $1,000,000 (under age 65)
Enter a multiple of $3,000 $_____ up to $30,000 (age 65-69)
Enter a multiple of $2,500 $_____ up to $5,000 (age 80-84), up to $10,000 (age 75-79), up to $20,000 (age 70-74).

☐ Dependent Child Life [3] $25,000

Dependent Information

If you are applying for coverage for your Child(ren), please provide the information requested below:

Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

OWNER INFORMATION (To be Completed by the Spouse/Domestic Partner, if enrolling for Spouse/Domestic Partner coverage)

NOTE: The Spouse/Domestic Partner of the NYSUT member is considered the owner of Spouse/Domestic Partner coverage. NYSUT Members do not need to complete this section.

Name of Owner (First, Middle, Last) if the owner is a person other than the member:	Date of Birth (MM/DD/YYYY)	Social Security # of Owner – –
Address (Street, City, State, Zip Code)		Phone #

[1] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest. [2] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor. [3]Amounts will be subject to state limits, if applicable.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and
GEF02-1
ADM *applies to residents of Connecticut, North Dakota and Utah)*

SUBMISSION INSTRUCTIONS - A separate form must be completed by each proposed insured.

After completion, sign and date the form on the last page where indicated. Make a copy for your records and return to:
Mercer Consumer, P.O. Box 9186, Des Moines, IA, 50306-9186.
Please note that coverage may not be available in all states. See your plan administrator for additional information.

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

HEALTH INFORMATION

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.

Your Name _____

Your height _____ feet _____ inches Your weight _____ pounds

	Yes	No
1. Are you now pregnant?	☐	☐
2. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
3. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☐
4. For residents of all states except CT, please answer the following question: Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? For CT residents, please answer the following question: To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder?	☐	☐
b. stroke or circulatory disorder?	☐	☐
c. high blood pressure?	☐	☐
d. cancer, Hodgkin's disease, lymphoma or tumors?	☐	☐
e. diabetes?	☐	☐
f. asthma, COPD, emphysema or other lung disease?	☐	☐
g. ulcers, stomach, hepatitis or other liver disorder?	☐	☐
h. colitis, Crohn's, diverticulitis or other intestinal disorder?	☐	☐
i. epilepsy, paralysis, seizures, dizziness or other neurological disorder?	☐	☐
j. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	☐	☐
k. multiple sclerosis, ALS or muscular dystrophy?	☐	☐
l. back, neck, knee, spinal, joint or other musculoskeletal disorder?	☐	☐
m. mental, anxiety, depression, attempted suicide or nervous disorder?	☐	☐
6. Are you currently taking any other prescribed medications?	☐	☐

GEF09-1
HEA
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana; and* **GEF09-1**
HEA *applies to residents of Connecticut, North Dakota and Utah)*

7. In the past 3 years, have you been Hospitalized as defined below (not including well-baby delivery)?	☐	☐
Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.		
8. In the past 2 years, have you used tobacco or nicotine in any form?	☐	☐

If you answered "Yes" to any of the above questions, you must also complete a Statement of Health form. Mercer Consumer will mail you the Statement of Health form upon receipt and review of this enrollment form.

GEF09-1
HEA-SUPP
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and
GEF09-1
HEA-SUPP *applies to residents of Connecticut, North Dakota and Utah)*

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1
FW
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and
GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

BENEFICIARY DESIGNATION

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked. I understand I have the right to change this designation at any time.

☐ Check if you need more space for additional beneficiaries including contingent beneficiary information, attach a separate page. Include all beneficiary information, and sign/date the page. If you are adding contingent beneficiaries, please indicate which beneficiaries are to be considered contingent.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any medical information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. For Members and Associate Members, I declare that I am actively at work on the date I am enrolling. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work. For Members, Associate Members or Retired Members, if I am not actively at work, I declare that I am able to perform the normal activities of a person of such age and sex with a like occupation or retired status on the date I am enrolling. I understand that if I am unable to perform such normal activities on the scheduled effective date of insurance, such insurance will not take effect until I am able to resume performing such activities.
3. I understand that if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
4. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Sign Here

Signature of Member _____ Print Name _____ Date Signed (MM/DD/YYYY) _____

Print Name _____ Date Signed (MM/DD/YYYY) _____

Sign Here

Signature of Owner/Spouse/Domestic Partner (if applicable) _____ _____

Print Name _____ Date Signed (MM/DD/YYYY) _____

GEF09-1 DEC

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and **GEF09-1 DEC** *applies to residents of Connecticut, North Dakota and Utah)*

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s)("employee", spouse, and any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB, Group Inc. ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information;
    medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, your employer for a plan administration purpose or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

Sign Here

Signature of Applicant		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

Premium Mode / Payment Option Section:
Select one mode of payment: ☐ Payroll Deduction (Please complete the Payroll Deduction Authorization) ☐ Pension Deduction (Please complete the Pension Deduction Authorization) ☐ Direct Bill Semi-Annually

The MetLife Term Life Insurance Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits has an endorsement arrangement of 7.61% of gross premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. The Insurer pools the premiums of Member Benefits participants who are insured for the purposes of determining premium rates and accounting. Coverage outside of this plan may have rates and terms that are not the same as those obtainable through Member Benefits. The Insurer or Member Benefits may hold premium reserves that may be used to offset rate increases and/or fund such other expenses related to the plan as determined appropriate by Member Benefits. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

▼ Return with application ▼

NYSUT MEMBER BENEFITS PAYROLL DEDUCTION AUTHORIZATION

NYSUT Member Benefits Trust **NYSUT Member Benefits Corporation** **NYSUT Member Benefits CMM Insurance Trust**

MEMBER BENEFITS NYSUT Working to Benefit You

(Please Print):

Last Name_____ First_____ Middle Initial____

Address_____ NYSUT ID #_____

Home Phone # _____Member's SS #_____

I hereby authorize my employer to deduct from each of my salary checks the deductions necessary for the purpose of NYSUT Member Benefits. Depending on the NYSUT Member Benefits program(s) which I am currently enrolled in and that deductions are taken for, monies will be forwarded to the appropriate NYSUT Member Benefits entity. For insurance plans, I understand that this authorization may be revoked at any time by written notice to the Plan Administrator. For plans with annual fees, I understand that I must provide written notice to the Plan Administrator to cancel automatic renewal and that I must satisfy the annual fee.

Signature of Employee_____ **Date**_____

Mail this completed form with your invoice to the address on the invoice. Please call 800-626-8101 with any questions.

Please check your union membership affiliation:

❒ *UFT* ❒ *UUP* ❒ *PSC/CUNY** ❒ *All other NYSUT Locals*

The amount of deductions will be determined by NYSUT Member Benefits based on the programs chosen, and may be adjusted to ensure that premiums are paid in full.

**This authorization card cannot be used to authorize deductions for PSC-CUNY Welfare Fund Benefits.*

▼ Return with application ▼

NYSUT MEMBER BENEFITS PENSION DEDUCTION AUTHORIZATION

NYSUT Member Benefits Trust **NYSUT Member Benefits Corporation** **NYSUT Member Benefits CMM Insurance Trust**

MEMBER BENEFITS nysut Working to Benefit You

(Please Print):

Last Name_____ First_____ Middle Initial_____

Address_____

Home Telephone No. ( )_____NYSUT ID #_____

Soc. Sec. #_____ Authorization is for_____
(name of plan)

Please Note: You must be retired for a minimum of six months to be eligible for pension deduction.

Read statements on the reverse side. Signature and date are required.

Mail this completed form with your invoice to the address on the invoice. Please call 800-626-8101 with any questions.

1.5K, 5/16, I-106

CHECK ONE BOX ONLY - SIGN AND DATE BELOW

❒ I belong to the Teachers' Retirement System of the **CITY of New York** (TRS) and I hereby request a monthly withholding of deductions from my monthly benefit for the purchase of union-sponsored benefits as permitted by Chapter 248, Laws of 1994. The TRS is authorized to continue taking such deductions until NYSUT Member Benefits receives written notice from me to the contrary.

❒ I belong to the New York City Board of Education Retirement System (BERS).

❒ I belong to the NYSUT Staff Pension Program.

❒ I belong to the New York **STATE** Teachers' Retirement System (NYSTRS), or

❒ I belong to the New York **STATE** Employees' Retirement System (NYSERS) and I hereby request monthly withholding of union deductions from my monthly benefit as permitted by Section 536 of the Education Law and Section 110-C of the Retirement Social Security Law. The NYSTRS or NYSERS is authorized to continue taking such deductions until NYSUT Member Benefits receives written notice from me to the contrary.

NYSERS #:_____

❒ I am a TIAA-CREF participant and hereby request a monthly withholding of deductions from my TIAA-CREF monthly lifetime annuity income for the purchase of coverages provided through NYSUT Member Benefits' Pension Advantage program. TIAA-CREF is authorized to continue taking such deductions until Member Benefits receives written notice to the contrary. If at any time the total deductions equal or exceed my combined monthly income payments from TIAA-CREF, all deductions I have authorized TIAA-CREF to take on my behalf will terminate immediately.

I expressly acknowledge and understand that NYSUT Member Benefits will determine the exact deductions to be withheld monthly and that any questions regarding the amount will be directed by me to Member Benefits. Depending on the NYSUT Member Benefits program(s) which I am currently enrolled in and that deductions are taken for, monies will be forwarded to the appropriate NYSUT Member Benefits entity as referenced on the reverse side. For insurance plans, I understand that this authorization may be revoked at any time by written notice to the Plan Administrator. For plans with annual fees, I understand that I must provide written notice to the Plan Administrator to cancel automatic renewal and that I must satisfy the annual fee. I hereby certify to the NYCTRS, NYSTRS, NYSERS, or TIAA-CREF that I am a member of NYSUT, an employee organization entitled to receive union deduction payments as provided by law.

*Signature*_____ *Date*_____

MetLife

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law**.** The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
Delaware American Life Insurance Company
MetLife Health Plans, Inc.
General American Life Insurance Company
SafeHealth Life Insurance Company

MetLife
Metropolitan Life Insurance Company, New York, NY

MIB PRE NOTICE

Information regarding your insurability will be treated as confidential. Metropolitan Life Insurance Company ("MetLife") or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company. MIB, upon request, will supply such company with the information in its file.

Upon receipt of the request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

MetLife, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

The Health Care Flexible Spending Account (HCFSA) Program and the Dependent Care Assistance Program (DeCAP) are divisions of the Office of Labor Relations' Flexible Spending Accounts Program.

PLAN YEAR 2023 ENROLLMENT/CHANGE FORM
FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM

nyc.gov/fsa

Print Form

Reset Fields

Please review the FSA Program Brochure on the FSA website, and Pages 3 and 4 of this form before completing.

PROGRAM (CHECK ONE): ❑ HCFSA *or* ❑ DeCAP *or* ❑ HCFSA and DeCAP

❑ **ENROLLMENT PERIOD:** Open Enrollment Period (October 17, 2022 - November 18, 2022) - ***Skip Section C***

❑ **MID-YEAR ENROLLMENT/CHANGE:** (January 1, 2023 - November 10, 2023) **- Please complete all appropriate sections, including Section C for mid-year enrollment.**

❑ **NEWLY ELIGIBLE EMPLOYEE:** Hire date: _____/_____/_____ Benefit effective date, if later than hire date: _____/_____/_____

❑ **CHANGE:** ❑ Name ❑ Address ❑ Agency Transfer ❑ Dependent ❑ Direct Deposit ❑ Annual Contribution

❑ HCFSA ONLY - Continuation of Coverage* to accelerate payroll deductions: Last pay date: _____/_____/_____ Last date at work: _____/_____/_____

* Continuation of Coverage: Please refer to page 3 for detailed information.

SECTION A — *Employee, Spouse and Dependent Information*

1. EMPLOYEE (PARTICIPANT) INFORMATION *(ALL SECTIONS MUST BE COMPLETED.)*

SOCIAL SECURITY NUMBER	DATE OF BIRTH	FEDERAL MARITAL STATUS
- -	/ /	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Legally Separated

AGENCY NAME (NOT DIVISION): (CUNY - PLEASE SPECIFY NAME OF COLLEGE)

Check here ❑ If you are on a weekly payroll.

LAST NAME	FIRST NAME	M.I.

HOME ADDRESS - NUMBER AND STREET	APT. NO.

CITY	STATE	ZIP CODE

DAYTIME PHONE NUMBER	MOBILE PHONE NUMBER	EMAIL ADDRESS
( ) -	( ) -	

2. SPOUSE INFORMATION *(PLEASE NOTE: DOMESTIC PARTNERS/CIVIL UNIONS ARE NOT ELIGIBLE FOR THE FSA PROGRAM.)*

SOCIAL SECURITY NUMBER	DATE OF BIRTH	EMPLOYMENT STATUS * Must provide proper documentation under DeCAP ** Not eligible under DeCAP *** Need description of occupation on letterhead stationery; or with no letterhead stationery, notarization is required
- -	/ /	❑ Employed ❑ Self-Employed*** ❑ Full-Time Student* ❑ Disabled* ❑ Unemployed**

LAST NAME	FIRST NAME	M.I.

3. DEPENDENT INFORMATION *(LIST ALL YOUR ELIGIBLE DEPENDENTS. CHECK THIS BOX ❑ IF ATTACHING AN ADDITIONAL PAGE.)*

FOR DeCAP: THE DEPENDENT MUST BE CLAIMED ON YOUR INCOME TAX RETURN AND UNDER THE AGE OF 13.

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	RELATIONSHIP TO EMPLOYEE			
					(CHECK ONE)	C	AC	DC
					C - CHILD UNDER AGE 13	C	AC	DC
					AC - CHILD AGE 13 THROUGH AGE 26	C	AC	DC
					DC - DISABLED CHILD	C	AC	DC

SECTION B — *Annual Contribution Amount* (January 1, 2023 - December 31, 2023)*

Health Care Flexible Spending Account	$_____ HCFSA	❑ Initial Annual Contribution: Minimum $260 - Maximum $3,050 ❑ Change Annual Contribution: ❑ Increase

* Your DeCAP and HCFSA annual contribution amount will be prorated over each paycheck. Please note that CUNY and DOE/Q Bank will be prorated over 24 paychecks.

Dependent Care Assistance Program	$_____ DeCAP	❑ Initial Annual Contribution: Minimum $500 - Maximum $5,000 ❑ Change Annual Contribution: ❑ Increase ❑ Decrease or ❑ Terminate (**Note**: If you are married and filing separate income tax returns, the maximum that you may allocate to DeCAP is $2,500.)

Does your spouse's employer offer a DeCAP that you take part in? ❑ No ❑ Yes If Yes, Dollar Amount $_____

The total combined Plan Year dollar amount for you and your spouse cannot exceed $5,000.

Please Sign Section F on Page 2.

Over ⟶

SECTION C — Mid-Year Qualifying Event Enrollment/Change

Please indicate the Qualifying Event incurred and attach appropriate documentation. All Qualifying Events MUST be submitted with appropriate documentation in order to be processed. This change must be consistent with your Qualifying Event and described on Page 3 of this Enrollment/Change Form. You must return this form within 30 days after the Qualifying Event indicated below.

Qualifying Event (Please Write):	Qualifying Event Date: / /

HCFSA and DeCAP - Qualifying Events and Required Documentation

- Marriage - Marriage certificate
- Birth of a child - Birth certificate
- Death of participant - Death certificate
- Adoption of a child - Adoption agreement and employee's tax return showing eligible dependents
- New employee - Letter from employer/agency
- Termination of employment (self) - Letter from employer/agency
- Approved unpaid leave of absence (during Open Enrollment Period) - Letter from employer/agency

DeCAP Only - Qualifying Events and Required Documentation

- Divorce/legal separation/annulment - Divorce, annulment decree/separation agreement
- Death (spouse or dependent) - Death certificate
- Change from FT to PT employment or vice versa-Letter from employer/agency (self, spouse)
- Approved unpaid leave of absence - Letter from employer/agency (self, spouse)
- Termination of employment - Letter from employer (self, spouse)
- Reduction or increase of hours worked - Letter from employer (self, spouse)
- Ineligibility of dependent - Birth certificate or other appropriate documentation

SECTION D — Direct Deposit Information - *(MUST ATTACH VOIDED CHECK)*

NOTE: If you participated in FSA in Plan Year 2022 and your Direct Deposit Information on file remains the same, you do not need to complete this section for Plan Year 2023.

***ABA NUMBER:** CHECKING ACCOUNT - THE ABA NUMBER IS THE FIRST NINE (9) NUMBERS PRIOR TO THE ACCOUNT NUMBER AT THE BOTTOM LEFT CORNER OF THE CHECK. SAVINGS ACCOUNT - CONTACT YOUR BANK FOR THE ABA NUMBER, IF NOT KNOWN. ****ACCOUNT NUMBER:** SEE CHECK, PASSBOOK, OR ACCOUNT STATEMENT FOR ACCOUNT NUMBER.

Account Type: (Check only one)	Person(s) Named on Account (Please Print Clearly)	ABA Number* (Must be 9 Digits)	Attach VOIDED Check Here
❑ Checking ❑ Savings	Person 1: _____ Person 2: _____	Account Number** (Please Write)	

SECTION E — Authorizations, Annual Salary Reduction Agreement and Certification of Qualifying Event

Authorization and Annual Salary Reduction Agreement

I have read the printed material explaining the HCFSA and/or DeCAP benefits and my choices under these programs. I have also read the Enrollment/Change Form information on Pages 3 and 4 of this form. I understand that by signing and submitting this Enrollment/Change Form, I am making a binding election as to my benefit coverage for the Plan Year that begins on January 1, 2023. I authorize my Employer to reduce my gross salary as indicated on this form in order to pay for the benefits I have elected. I understand that my payments will be pro-rated over each payroll period.

NOTE: I understand that my HCFSA election cannot be reduced or revoked for any reason except for termination of employment during the Plan Year, or if I should take an unpaid leave of absence. I agree to pay, in full, the amount elected on this form for the Plan Year for HCFSA, by recalculating the payroll deductions upon returning from unpaid leave. My HCFSA and/or DeCAP election can only be changed if I experience a Qualifying Event (Section C). I further understand that each account is separate and that DeCAP funds cannot be used for or transferred to HCFSA or vice-versa. I understand that any amount remaining in these FSAs that is not used during the Plan Year and HCFSA Grace Period, if applicable, will be permanently forfeited by me. I understand that I am only eligible to receive reimbursement on behalf of my eligible dependents listed on this form.

I understand that I will be terminated from participation in the Program if I cease employment with the City of New York or go on an unpaid leave of absence, unless I elect to participate in the Continuation Coverage for HCFSA.

Direct Deposit Authorization

I hereby authorize the Flexible Spending Accounts Program to deposit my HCFSA/DeCAP reimbursement directly into my checking or savings account as requested. I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the "National Automated Clearing House Association" operating guidelines and rules, the Flexible Spending Accounts Program can only reverse the amount of the incorrect direct deposit. I agree that this authorization will remain in effect until I provide to the Flexible Spending Accounts Program a written cancellation to terminate the service. I will notify the Flexible Spending Accounts Program if my bank account numbers listed above should change.

Mid-Year Qualifying Event

This is to certify that I incurred the Qualifying Event indicated in Section C and, therefore, wish to modify my benefits as indicated. I understand that the change(s) in benefits requested must be consistent with the Qualifying Event, and that I must provide approved documentation of all change(s), and that the effective date of the change(s) will be the date the forms are received by the Plan Administrator or the date of my first payroll deduction if I become eligible after the beginning of the Plan Year. The participant has the burden of proof to show that the Qualifying Event is acceptable under the Plan. The Plan Administrator reserves the right to request additional information. The Plan Administrator has, among other duties, the power and duty to interpret the Qualifying Event and to resolve ambiguities, inconsistencies and omissions.

SECTION F — Employee/Participant Signature

SIGNATURE:	DATE: / /

Please submit this form electronically to: *https://nyc-fsa.leapfile.net*
Retain a copy for your records

DO NOT WRITE IN THIS AREA

Payroll				
Program	Initials	Date	PMS DOC#	Other Payroll
HCFSA		/ /		
DeCAP		/ /		

Database	
Initials	Date
	/ /
	/ /

Agency Payroll Code
New York State I.D. Number

The Health Care Flexible Spending Account (HCFSA) Program and the Dependent Care Assistance Program (DeCAP)
are divisions of the Office of Labor Relations' Flexible Spending Accounts Program

PLAN YEAR 2023 ENROLLMENT/CHANGE FORM
FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM

nyc.gov/fsa

By signing the Enrollment/Change Form:

- I authorize my Employer to reduce my gross salary before federal income taxes and Social Security (FICA) taxes are calculated by the total amount of the annual salary reduction (Plan Year 2023 contribution amount) indicated on Page 1.
- I understand that contributions to the FSA Program may reduce my Social Security benefits, since Social Security contributions will be based on my adjusted gross salary.
- I authorize the FSA Program to deposit my HCFSA/DeCAP reimbursement directly into my checking or savings account as requested (See Section D).

Under HCFSA

- I understand that the amount of salary reduction will continue throughout the Plan Year and cannot be reduced or revoked for any reason except for termination of my employment during the Plan Year or if I should take an unpaid leave of absence.
- I understand that I may enroll in the Program or increase my contribution should I become eligible to participate in this Program or acquire new dependents during mid-year. I understand that I must complete all applicable sections of this form and submit it to the FSA Program Administrator within thirty (30) days after a Qualifying Event in order to enroll and/or add dependents. A Qualifying Event can be marriage, adoption or birth of a child, commencement of new employment with the City, or employee's return from approved unpaid leave of absence (taken during the Open Enrollment Period) or termination of participant's employment with the City of New York.
- I understand that I will be reimbursed for eligible expenses up to my total annual contribution amount, less the administrative fee and any claims previously reimbursed, regardless of the current balance in my account.
- I understand that any health care expense defined by the IRS as a non-deductible expense for income tax purposes shall be ineligible for reimbursement. I further understand that although an expense may be deductible for income tax purposes, it may be ineligible for reimbursement under this Program.
- I understand that my personal and claim information will not be released to any other individual unless I complete the Health Insurance Portability and Accountability Act (HIPAA) Protected Health Information (PHI) Authorization Form.
- I understand that I have the right to revoke my HCFSA HIPAA authorization at any time in writing by emailing the Program through the FSA website at nyc.gov/fsa.

HCFSA Continuation of Coverage - Employees Terminating Employment/Unpaid Leave of Absence

If you terminate your employment with the City of New York or go on an unpaid leave of absence during the Plan Year, you cannot submit any claims for services rendered after your termination date, or effective date of your unpaid leave of absence, unless you elect Continuation of Coverage. You may elect to deduct the remaining balance of your goal amount on a pre-tax basis either by lump-sum or pro-rated payroll deductions with the remaining paychecks, as long as the FSA Program Administrator is able to meet the payroll deadlines for the applicable pay dates. Otherwise, you may continue coverage by submitting payment to the FSA program with post-tax dollars.

- I understand that I will be terminated from participation in the HCFSA Program, unless I elect HCFSA Program Continuation Coverage. In this case, I agree to fund the balance of my HCFSA goal amount for the current Plan Year with either (a) pre-tax dollars deducted from my last paycheck(s) or accelerated for the remaining paychecks prior to leaving City service; or (b) post-tax dollars for the remainder of the current Plan Year.
- I understand that if I elect HCFSA Program Continuation Coverage and would prefer that the balance of my goal amount for the current Plan Year be deducted from my last paycheck(s) or accelerated for the remaining paychecks on a pre-tax basis, I will notify the FSA Program Administrative Office in writing by emailing the Program through the FSA website at nyc.gov/fsa thirty (30) days prior to the date I cease employment, or as soon as possible in order for the FSA Program Administrator to meet payroll deadlines.
- I understand that if I take an unpaid leave of absence, I must notify the FSA Program Administrative Office to recalculate the deduction amount upon my return from the unpaid leave of absence and the FSA Program Administrative Office may also recalculate the deduction amount if necessary as long as it is within the same calendar year and within the payroll cut-off dates.
- I authorize the FSA Program Administrative Office to recalculate any missed HCFSA payroll deduction amounts, if the FSA Program Administrator identifies such missed deductions.

Under DeCAP

- I understand that the amount of salary reduction will continue throughout the Plan Year, unless I incur an approved Qualifying Event. I understand that I must complete all applicable sections of this form and submit it to the Plan Administrator within thirty (30) days after a Qualifying Event in order for any change to be effective.

- I understand that I may enroll in the Program or increase my contribution should I become eligible to participate in this Program or acquire new dependents during mid-year. I understand that I must complete all applicable sections of this form and submit it to the Plan Administrator within thirty (30) days after a Qualifying Event in order to enroll and/or add dependents. A Qualifying Event can be marriage, adoption or birth of a child, commencement of new employment with the City, employee's return from approved unpaid leave of absence (taken during the Open Enrollment Period) or termination of participant's employment with the City of New York.
- I understand that I will be reimbursed up to the total current balance in my account less the administrative fee. Any amounts requested for reimbursement which exceed the current balance in my account will be carried forward to the next month.
- I understand that if I am married and my spouse is not employed, he/she must be either: a) incapable of self-care or b) a full-time student.
- I understand that I may not receive a benefit for eligible employment-related dependent care expenses incurred by me which is in excess of my Earned Income or the Earned Income of my spouse, if I am married.

Under HCFSA and DeCAP

- I understand that if I do not experience accurate payroll deductions, it is my responsibility to notify the FSA Program immediately.
- I understand that the funds in these FSAs can only be paid out to reimburse eligible medical and/or dependent care expenses actually incurred after the start of my participation in the FSA Program and during the Plan Year and HCFSA Grace Period, if applicable.
- I understand that I have the burden of proof to show that each medical and/or dependent care expense is reimbursable under the FSA Program, as well as eligible and reimbursable under all regulations (including the Internal Revenue Code).
- I understand that, under all circumstances, the FSA Program Administrator reserves the right to request additional information.
- I understand that the FSA Program Administrator has, among other powers and duties, the power and duty to interpret the FSA Program and to resolve ambiguities, inconsistencies, and omissions.
- I understand that if I participate in both the HCFSA Program and DeCAP, I cannot transfer funds from one account to the other.
- I understand that there is a maximum administrative fee of $4.00 per month per account.
- **I understand that any amount remaining in these FSAs that is not used during the Plan Year, Claims Run-Out Period and HCFSA Grace Period, if applicable, will be permanently forfeited by me.**

Commuter Benefit Solutions Edenred www.commuterbenefitsnyc.com

THE CITY OF NEW YORK COMMUTER BENEFITS PROGRAM

TRANSITBENEFIT PLANS

Submit completed form to: Your College TransitBenefit Coordinator www.cuny.edu/transitbenefit www.commuterbenefitsnyc.com

EMPLOYEE ACTION

☐ **NEW** (Enroll)

☐ **CHANGE PERSONAL INFORMATION** (Change Mailing address, Email or Telephone)

☐ **CHANGE DEDUCTION** (Change Transit Plan and/or Amount Deducted from Pay each Month)

☐ **SUSPEND DEDUCTION** (Temporarily Stop Transit Plan Deduction from Pay)

☐ **CANCELLATION** (Terminate Your Transit Plan Payroll Deduction)

EMPLOYEE IDENTIFICATION (All fields in this section are required and must be filled out completely. Please Print.)

Social Security / ERN	DOB MM_____ /DD_____/YYYY_____		
Name (First/Middle/Last)			
Address Line 1			
Address Line 2**			
City/ State/Zip			
Email Address		**Telephone**	

*Located on your pay statement or check stub. ** Apt.#, Fl.# or Box# if applicable.

TRANSIT PLAN AUTHORIZATION

(Please select One of the following plans by writing your initials in the column next to the Transit Plan of your choice. Please enter the total amount, including dollars and cents, you want deducted from your pay each month.)

ACCESS-A-RIDE ($2.05 Monthly Admin Fee through Payroll Deductions)		**COMMUTER CARD - Unrestricted** ($1.25 Monthly Admin Fee through Payroll Deductions)		**TRANSIT PASS** ($2.05 Monthly Admin Fee through Payroll Deductions)	
Employee Initials	**Monthly Deduction Amount***	Employee Initials	**Monthly Deduction Amount***	Employee Initials	**Monthly Deduction Amount***
	$		$		$

*For the Commuter Card-Unrestricted, Transit Pass and Access-A-Ride plans you may elect any amount up to $800.

SUSPEND TRANSIT PLAN DEDUCTION

Submit at least 2 weeks before you want to suspend your deduction. Remember, administrative deductions will continue when applicable. If you are also enrolled in the Commuter Benefits Parking Plan, the parking plan will be suspended for the same period. Please note this will only suspend your payroll deduction. To also suspend your transit pass orders you must do so directly with Edenred Commuter Benefit Solutions at www.commuterbenefitsnyc.com or (833) 584-8109.

PAY DATE TO SUSPEND DEDUCTION MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐☐☐

PAY DATE TO RESUME DEDUCTION MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐☐☐

EMPLOYEE CERTIFICATION

I hereby authorize The City University of New York to deposit my payroll deduction as indicated above into my ECBS Commuter Benefits Transit Account.

I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the "National Automated Clearing House Association" operating guidelines and rules, The City University of New York can only reverse the amount of the incorrect direct deposit.

I understand, according to the Internal Revenue Code, that the average monthly amount of my transportation deductions should not exceed my average monthly cost of public transportation to and from work. If my average monthly cost of public transportation to and from work should change, I will change my deduction plan to accommodate my new circumstance. Furthermore, no reimbursement will be provided for pre-tax transportation fringe deductions. Upon cancellation, voluntary or otherwise, any funds remaining in my Transit Account will be available for use for a period of 90 days from the effective date of cancellation. Residual funds remaining in the account beyond the 90 day period will be forfeited.
I understand there is a monthly fee to cover administrative costs of the program. Said fee will be deducted from my post-tax pay each month. The administrative charge is non-refundable. The administrative fees and charges are as follows:

TRANSIT PLAN	**FEE**	**CHARGE METHOD**
Access-A-Ride	**2.05**	**Deducted from post-tax pay**
Commuter Card-Unrestricted	**1.25**	**Deducted from post-tax pay**
Transit Pass	**2.05**	**Deducted from post-tax pay**

I grant authorization for The City University of New York to provide my enrollment information, including mailing address, phone number and e-mail address to Edenred Commuter Benefit Solutions for uses exclusively related to the administration of the program. I understand that this authorization will remain in effect until I submit a new request for a change or cancellation.
I understand that my Commuter Benefits transit account balance and information will be maintained by ECBS and are accessible online at www.commuterbenefitsnyc.com or by calling ECBS Customer Service at (833) 584-8109.

Employee Signature _____ **DATE** MONTH ☐☐ DAY ☐☐ YEAR ☐☐☐☐

AGENCY PAYROLL SECTION

Payroll #	**Personal information updated in NYCAPS (check all that apply):** ☐ **Mailing Address** ☐ **Email Address** ☐ **Phone Number**	**PI ENTRY DATE** MONTH ☐☐ DAY ☐☐ YEAR ☐☐☐☐

I certify that the above data was entered into PI:

Prepared By (Please Print)	**Signature**	**Date**

(04/2019)

PLAN YEAR **2023** ENROLLMENT/CHANGE FORM

MEDICAL SPENDING CONVERSION (MSC)

HEALTH BENEFITS BUY-OUT WAIVER PROGRAM

nyc.gov/fsa

Employee (Participant) return completed form to:

Agency Benefits Office, NYCAPS Central or HR Shared Services Office. See instructions on reverse side.

INSTRUCTIONS: Please review the MSC Health Benefits Buy-Out Waiver section in the Flexible Spending Accounts (FSA) Program Brochure, which is on the FSA website at nyc.gov/fsa. Also, see instructions on reverse side of this form before completing.

ENROLLMENT ***(Check one):***

❑ Open Enrollment (October 17 - November 18, 2022; effective January 1, 2023) Complete Sections I, II, and IV.

❑ Mid-Year Enrollment (January 1 - November 10, 2023; effective Qualifying Event date) Complete Sections I, II, III, and IV.

I. EMPLOYEE (PARTICIPANT) INFORMATION (Please Print)

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

HOME ADDRESS - NUMBER AND STREET	APT

CITY	STATE	ZIP CODE + FOUR
		-

HOME PHONE NUMBER	WORK PHONE NUMBER	MOBILE PHONE NUMBER	E-MAIL
( ) -	( ) -	( ) -	

AGENCY NAME (NOT DIVISION):CUNY EMPLOYEES PLEASE SPECIFY THE NAME OF COLLEGE

II. MSC HEALTH BENEFITS BUY-OUT WAIVER PROGRAM SECTION: If completing this section during mid-year, you must also complete Section III below.

A) ***To participate*** in the Buy-Out Waiver Program, complete this form and a Health Benefits Application or submit through ESS. Return both forms to your agency's Human Resources Department/NYCAPS (if applicable) for approval and completion.

❑ **I wish to participate in the Buy-Out Waiver Program.** Check *one*

Non-City group health plan provider (company name) _____

❑ Individual Coverage ($500) ❑ Domestic Partner/Civil Union Coverage ($500) ❑ Family Coverage ($1,000)

Please note: You must attach proof of non-City group health coverage (letter or health insurance card).

B) ***To terminate*** your participation in the Buy-Out Waiver Program, you must complete this form and a Health Benefits Application, or submit through ESS, for reinstating City health benefits. Return both forms to your agency's Human Resources Department/NYCAPS (if applicable) for approval and completion.

❑ **I wish to withdraw from the Buy-Out Waiver Program.**

III. MID-YEAR QUALIFYING EVENT: Newly eligible employees or current employees changing their status during mid-year must complete this section.

This is to certify that I incurred the Qualifying Event indicated below and, therefore, wish to modify my benefits as indicated. I understand that the change(s) requested must be consistent with the Qualifying Event and that I must submit this form with legal/supporting documentation of all changes to my agency's Human Resources Department/NYCAPS (if applicable) and they must be received by the MSC Administrative Office within 30 days after the Qualifying Event to take effect.

Date of Qualifying Event: ____/____/ 2023 | Today's Date: ____/____/ 2023

If Today's Date is more than 30 days from the Date of Qualifying Event, please note that you are not eligible for Plan Year 2023.

Please check one of the following:

Employment Status: Documentation must be provided by employer/agency

❑ Beginning/termination of employment (❑ self ❑ spouse)
❑ Unpaid leave of absence (❑ self ❑ spouse)
❑ Return from unpaid leave of absence (❑ self ❑ spouse)
❑ Change from P/T to F/T employment or vice versa (❑ self ❑ spouse)
❑ Increase in health plan deductions by more than 20%

Family Status Change: Legal documentation must be provided by participant

❑ Marriage/domestic partner
❑ Birth or adoption of child
❑ Divorce
❑ Ineligibility of dependent (❑ age ❑ marriage)

IV. Employee Signature

I have read the MSC Program materials and instructions and I attest that I meet the qualifications to enroll or withdraw from the MSC Health Benefits Buy-Out Waiver Program.

Signature:_____ Date: ____/____/____

V. FOR COMPLETION BY EMPLOYING AGENCY'S HUMAN RESOURCES DEPARTMENT/NYCAPS/HR SHARED PERSONNEL ONLY:

Please review the above information and submitted documentation from employee before completing the information below.

Note to Benefits/Payroll/NYCAPS/HR Shared Officer:

- Send this MSC Form and the Health Benefits Application, along with any legal/supporting documentation, electronically to: ***https://nyc-fsa.leapfile.net***
- You should retain a copy of this form for your records.

1) ***For the Health Benefits Buy-Out Waiver Program*** (Section II), I have reviewed and processed the Health Benefits Application and certify that the employee has listed a non-City group health insurance policy under which he/she is covered. I have notified the appropriate health insurance carrier of this change.

2) ***For mid-year changes, I certify that a Qualifying Event*** listed in Section III has occurred within 30 days after this request *and* this form, along with legal/supporting documentation, have been submitted.

Employee's Agency Appointment Date: ____/____/____ Effective Date of Health Benefits: ____/____/____

A) **MSC Buy-Out Waiver Effective Date: (Check one)**

❑ Open Enrollment: (October 17 - November 18, 2022: effective January 1, 2023)

❑ Mid-Year Enrollment: ____/____/ 2023 (January 1, 2023 - November 10, 2023)

(June 1- June 30, effective July 1, 2023) (December 1- December 31, effective January 1, 2024)

B) **MSC Buy-Out Waiver Withdrawal Date: (Check one)**

❑ Open Enrollment: (October 17 - November 18, 2022: effective January 1, 2023)

❑ Mid-Year Withdrawal: ____/____/ 2023 (January 1, 2023 - November 10, 2023)

AGENCY BENEFITS MANAGER/NYCAPS/HR SHARED PERSONNEL SIGNATURE	EFFECTIVE DATE	WORK PHONE NUMBER
	/ /	( ) -

EMPLOYEE AGENCY CODE	CUNY STATE I.D. NUMBER	E-MAIL ADDRESS

MSC ADMINISTRATIVE OFFICE USE ONLY

ENROLLMENT EFFECTIVE DATE	WITHDRAWAL EFFECTIVE DATE	PROCESSING DATE	PROCESSOR	AGENCY PAYROLL CODE
/ /	/ /	/ /		

MEDICAL SPENDING CONVERSION (MSC)
PLAN YEAR 2023

INSTRUCTIONS:

HEALTH BENEFITS BUY-OUT WAIVER PROGRAM - SECTION II:

The Medical Spending Conversion (MSC) Health Benefits Buy-Out Waiver Program allows you to receive an incentive payment for waiving your City health benefits. Refer to the MSC Health Benefits Buy-Out Waiver Program section in the Flexible Spending Accounts Program Brochure for detailed information.

A. Enrolling:

Please Note: The Internal Revenue Service does not permit any retroactive participation from a previous Plan Year.

If you are covered under your spouse's/domestic partner's or parent(s)' non-City group health insurance, or a group health plan available through other employment, you may waive New York City health benefits. Once your enrollment form has been processed and approved, you will receive a confirmation letter from the MSC Administrative Office. Please contact your agency's Human Resources Department/NYCAPS/HR Shared personnel if you do not receive a confirmation letter.

Current employees: You may enroll in the Program during the Open Enrollment Period (October 17, 2022 - November 18, 2022) for an effective date of January 1, 2023. You must complete Sections I, II, and IV. Section V is to be completed by your agency's Human Resources Department/NYCAPS/HR Shared personnel.

Newly eligible employees: You may enroll in the Program within thirty (30) days after becoming eligible for City health benefits. You must complete Sections I, II, III, and IV. Section V is to be completed by your agency's Human Resources Department/NYCAPS/HR Shared personnel.

During mid-year: If you incur a Qualifying Event, you must notify the MSC Program Administrative Office within thirty (30) days after the Qualifying Event in order to participate. You must complete Sections I, II, III, and IV and attach legal/supporting documentation. Section V is to be completed by your agency's Human Resources Department/NYCAPS/HR Shared personnel.

Any MSC Form received in June will be effective July1st of that Plan Year. Any MSC Form received in December will be effective January 1st of the following Plan Year.

By signing the MSC Health Benefits Buy-Out Waiver Program Enrollment/Change Form, you elect to receive $1,000 (family coverage waived), $500 (individual coverage waived), or $500 (domestic partner/civil union coverage waived) annually in lieu of New York City health benefits. You will receive $500 for family coverage, $250 for individual coverage, or $250 for domestic partner/civil union coverage waived at the end of every six-month calendar period. Please note that same sex marriage will be treated as family coverage **(This amount will be pro-rated for any period less than six months by the number of days you are in the Health Benefits Buy-Out Waiver Program.)**

An employee participating in the City's Deferred Compensation Plan (DCP) in lieu of FICA and participating in the Health Benefits Buy-Out Waiver Program (taxable income), may need to increase his/her salary deferral percentage to an amount higher than 7.5% of annual salary in order to account for the increase in income due to the "Buy-Out Waiver Incentive Payment." If the 7.5% of total salary income requirement is not met, the participant who is enrolled in the DCP may have to continue to pay FICA taxes until that requirement is met.

B. Terminating:

Your waiver will remain in effect during the Plan Year unless a) you experience an approved mid-year Qualifying Event or, b) you reinstate your City health coverage during the Health Benefits Program Fall Transfer Period. During the mid-year, your form must be received by the MSC Administrative Office within thirty (30) days after the Qualifying Event in order for the change to be effective. If you are returning from an approved leave of absence or transferring to a new City agency, you must complete the MSC Health Benefits Buy-Out Waiver Program Enrollment/Change Form and the Health Benefits Application within thirty (30) days after such event to be reinstated, or to receive a pro-rated incentive payment.

If you wish to terminate your participation in the Health Benefits Buy-Out Waiver Program and reinstate your City health benefits coverage, complete Section II, by indicating your requested change. If you are terminating your participation mid-year, you must also complete Section III.

Please Note: If you waive City health coverage, you must have other non-City group health coverage available to you. The Health Benefits Application must accompany this MSC Form so that your agency's benefits/payroll manager is able to verify that you have other coverage. Your agency's Human Resources Department/NYCAPS/HR Shared personnel may request additional documentation.

This form is not valid if you have not completed Sections I, II, III (for mid-year Qualifying Event) and IV.
This form is not valid if Section V has not been completed by your agency's Human Resources Department/NYCAPS/HR Shared personnel.

Please return the completed form and documentation to:

- If your agency is a non-centralized agency - Send directly to your agency benefits office.
- If your agency is a centralized agency - Send directly to: NYCAPS Central, 1 Centre Street, New York, NY 10007
- DOE Employee/Payroll/Secretary - Send directly to: DOE MSC Unit, 65 Court Street, Rm. 102B, Brooklyn, NY 11201
- H+H Centralized Agency - Please upload via Employee Self Service and contact HR Share Services at 646-458-5634 for additional assistance.

2023 Salary Reduction Agreement

Employee Name: _____

Address: _____ Date of Hire: _____

_____ Date of Birth: _____

College: _____

CUNYfirst Employee ID: _____

Telephone Number: _____

2023 Contribution Limits

Under age 50..... $22,500

Age 50 or over..... $30,000

The undersigned parties agree that the employee ("you") will participate in the CUNY-sponsored 403(b) Plan (also known as the TDA plan) administered through TIAA and that, with respect to amounts paid on or after_____, which is after the date this Agreement is signed, your salary shall be reduced by the amount indicated below, and the employer will contribute that salary reduction amount to the CUNY-sponsored 403(b) Plan as either a pretax contribution or a post-tax Roth contribution.

You must specify a salary reduction percentage (in **whole percentages**) in the space provided below. Salary Reduction Agreements without a whole percentage number will not be accepted. Salary reductions to the CUNY-sponsored 403(b) Plan, either pretax or Roth, are made after all other mandatory CUNY deductions.

This Agreement shall be legally binding and irrevocable as to each of the parties hereto while employment continues and will only cover amounts paid while in effect. It will remain in effect unless it is revised or terminated, and no annual renewal is required. This Agreement may be terminated or modified by either party as of the end of any month with at least 60 days prior written notice. Only three modifications can be made to this Agreement during a calendar year; however, this Agreement may be terminated during a year even if three prior modifications have been made.

You agree to hold the City University of New York harmless under this Agreement, provided that any and all sums withheld by the employer pursuant to this Agreement are remitted to the vendor you designated to purchase non-forfeitable contracts in accordance with Section 403(b) of the Internal Revenue Code of 1986, as amended.

I elect to reduce my annual salary by the percentage listed below provided that this percentage does not exceed the maximum allowed by Section 415 and 402(g) of the Internal Revenue Code as listed above. If I am age 50 or older during the year, the maximum deferral limit listed above will include the additional catch-up contribution permitted under Section 414(v) of the Internal Revenue Code.

Please check the appropriate box(es) below and designate the percentage you wish to contribute. You may contribute to the CUNY-sponsored 403(b) Plan using the pretax or Roth (post-tax) contribution options; however, these combined amounts must not exceed the maximum amount allowed under Section 415, 402(g) and 414(v) of the Internal Revenue Code as indicated above. You are responsible for tracking and reporting the amounts of your contributions to all your employers.

☐ _____% of compensation (as defined under the 403(b) Plan) as a pretax TDA contribution

☐ _____% of compensation (as defined under the 403(b) Plan) as a post-tax Roth contribution

EMPLOYEE

Print Name: _____

Signature: _____

Date: _____

CUNY

By: 

Antony J. La Bozetta, PHR

University Retirement Plan Asset Officer

For questions, please call TIAA at **866-277-7957**.

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 Gated EPO
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 PPO*
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.