Beginning of Image Text:

**American University**

**Health Benefits Program**

**Application/Change Form**

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

**Example of Information to Be Collected**

- **Reason(s) for Submission** (Check one or more boxes. Enter change date, if appropriate)
  - New Enrollment
  - Reinstatement
  - Retire (Whole Retirement)
  - Buy-Out Waiver Program
  - For Returning Employees
  - Change of Employment Status
  - Other

- **Employee/Retiree Information**
  - Last Name:
  - First Name:
  - M.I.:
  - Social Security Number:
  - Date of Birth:
  - Sex:
  - Work Telephone Number:
  - Mobile/Home Telephone Number:
  - E-mail Address:
  - City:
  - State:
  - Zip Code:
  - Country (if outside the U.S.):
  - City Agency Name:
  - City Agency Code:
  - Title Code:
  - Status:
  - Appointment/Retirement Date:
  - Pay Period:
  - Effective Date of Coverage:
  - Effective Date of Coverage:
  - Effective Date of Coverage:
  - Effective Date of Coverage:

- **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)
  - Access to Benefits
  - Waive Benefits
  - Add Optional Benefits
  - Waive Benefits
  - Add Optional Benefits

- **Transfer of Health Plan** (For Retiring Employees)
  - Transfer Period
  - Move Into/Out of Health Plan Area
  - Effective Date of Coverage:

- **Certifying Signature**
  - Date:
  - Telephone Number:

- **Additional Information**
  - Employment Verification:
  - Advocate for Health Benefits:
  - To participate in the Health Benefits Program:
  - To make changes to your Health Benefits Program:
  - To obtain information about additional cost for family coverage:

- **Application/Change Form**
  - Your Agency’s Payroll or Personnel Office:
  - Your Agency’s Payroll or Personnel Office:
  - For Domestic Partner:
  - For Domestic Partner:

- **Return Form to**
  - Attn: Domestic Partner Unit
  - New York, NY 10001

- **Contact Number**
  - (212) 513-0470

- **Website**
  - www.nyc.gov/olr

- **Return to**
  - Personnel Office
  - Payroll or Your Agency’s Health Benefits Program

- **Return Form to**
  - Employees
  - Retirees

End of Image Text.
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 Waiver Program.

Section I: Your signature is required in this section to enroll or effect the changes requested on this Application/Change Form.

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

See top, right-hand corner of reverse side for instructions on submitting this Application/Change Form. Retain a copy for your records.
Health Plans Available to
Employees, Non-Medicare Retirees and their Dependents

Aetna EPO
Cigna HealthCare
DC 37 Med-Team (DC 37 members only)
Empire EPO
Empire HMO
GHI-CBP/Empire BlueCross BlueShield
GHI HMO
HIP Prime HMO
HIP Prime POS
MetroPlus Gold
Vytra Health Plans

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

Health Plans Available to
Medicare-Eligible Retirees and their Dependents

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

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

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