



# 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	Health Benefits Program 40 Rector Street - 3rd Fl. New York, NY 10006 FAX: (212) 306-7756	Health Benefits Program 40 Rector Street - 3rd Fl. New York, NY 10006 Attn: Domestic Partner Unit

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

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

### REASON(S) FOR SUBMISSION (Check one or more boxes. Enter change date, if appropriate)

<b>A.</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement* <input type="checkbox"/> Retirement <input type="checkbox"/> Disability Retirement* <input type="checkbox"/> Accident Disability Retirement <input type="checkbox"/> Drop Optional Benefits* *Please indicate Effective Date: ____/____/____	<input type="checkbox"/> Add Optional Benefits* <input type="checkbox"/> Waive Benefits* <b>EMPLOYEES ONLY:</b> <input type="checkbox"/> Buy-Out Waiver Program <small>COMPLETE SECTIONS D, E, F &amp; H</small>	<b>B. Change of:</b> <input type="checkbox"/> Spouse/Domestic Partner: <input type="checkbox"/> Add <input type="checkbox"/> Drop Effective Date: ____/____/____ <input type="checkbox"/> Dependent Child(ren): <input type="checkbox"/> Add <input type="checkbox"/> Drop Effective Date: ____/____/____ <input type="checkbox"/> Change of Name - Former Name: _____	<b>C. Transfer of Health Plan and/or Optional/Benefit Based on:</b> <input type="checkbox"/> Transfer Period <input type="checkbox"/> Move Into/Out of Health Plan Area Effective Date: ____/____/____ <input type="checkbox"/> Retiree Once-in-A-Lifetime Effective Date: ____/____/____
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### D. EMPLOYEE/RETIREE INFORMATION

Last Name:		First Name:		M.I.:	Social Security Number:		
Home Address:							Apt.:
City:		State:	Zip Code:	Country (if outside the U.S.):			
Date of Birth:	Sex:	Work - Telephone Number:		Mobile/Home - Telephone Number:		E-mail Address:	
/ /	<input type="checkbox"/> M <input type="checkbox"/> F	( ) -		( ) -			
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Date of Event (mm/dd/yy)	Agency in which employed or retired from:		Union or Welfare Fund:		
	<input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partnership	/ /					
Name of current City Health Plan:			Are you Medicare eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>ATTACH COPY OF CARD</b>	
			If YES, please attach a copy of your Medicare card to this application.				

### 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:	
							/ /	
Is spouse/domestic partner: <input type="checkbox"/> Employed (Double City coverage is not permitted) <input type="checkbox"/> Retired (Double City coverage is not permitted) <input type="checkbox"/> Not Employed								
<input type="checkbox"/> City Agency Name: _____ <input type="checkbox"/> Non-City Related								
Does spouse/domestic partner have Non-City group health plan?				Is your spouse/domestic partner Medicare eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Yes <input type="checkbox"/> No				If YES, please attach a copy of his/her Medicare card to this application.				
<b>ATTACH COPY OF CARD</b>								

### 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.)

Last Name:	First Name:	Date of Birth:	Social Security Number:	Sex:	ADD COVERAGE	DROP COVERAGE	PERMANENTLY DISABLED*
Dependent		/ /	- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependent		/ /	- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependent		/ /	- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependent		/ /	- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependent		/ /	- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

### 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 (RETIRES 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:	Appointment/Retirement Date:	Pay Period:	Effective Date of Coverage:
		<input type="checkbox"/> Full-Time <input type="checkbox"/> Permanent <input type="checkbox"/> Part-Time <input type="checkbox"/> Provisional	/ /	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly	/ /
Retirement System (For Retiring Employees):		Years of Credited Service:	City Start Date:	Retirement Date:	Pension Number:
			/ /	/ /	
Certifying Signature:			Date:	Telephone Number:	
			/ /	( ) -	

## ***Instructions for Completing a Health Benefits Application/Change Form***

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- 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](http://nyc.gov/hbp), for a list of all dependent eligibility documentation requirements for health benefits coverage for dependents.  
Check Dependent Child(ren) Add or Drop if you are adding or dropping a dependent child. If you are adding a dependent child, you must attach a copy of either the birth certificate, or documents proving guardianship or adoption.  
If changing your name, please indicate your former name and provide documentation of name change.
- Section C:** Check Transfer Period if the change you are requesting (such as Adding Optional Benefits or Changing Plans) is being made during a Transfer Period.  
Check Permanent Move Into/Out of Health Plan Area if you are requesting to change plans as a result of either moving out of the service area of your current plan, or if you are moving into the service area of another plan.  
Check Retiree Once in a Lifetime if you are requesting to change plans or add optional benefits anytime other than a transfer period.
- Section D:** If you are enrolled in Medicare Parts A & B, you must attach a photocopy of your Medicare card.
- Section E:** If you are married or have a domestic partner, this section must be completed only if you are covering your spouse/domestic partner.  
If your spouse/domestic partner is enrolled in health plan other than your City coverage or Medicare, you must indicate so.  
If your spouse/domestic partner is enrolled in Medicare Parts A & B, you must attach a photocopy of his/her Medicare card.
- Section F:** List **ALL** eligible dependent children to be covered. If a dependent child is permanently disabled, and on Medicare, you must attach a photocopy of his/her Medicare card. (CUNY ADJUNCT EMPLOYEES: City rates apply for Individual coverage ONLY. Contact your Benefits Office for information about additional cost for Family coverage.)
- Section G:** Write the complete name of your current health plan or the plan you are selecting (see back of sheet). If you do not make an optional rider selection, you will be given basic coverage only.
- Section H:** This section is for employees only who wish to participate in the Buy-Out Waiver Program. Remember to date your form. **Retirees, Line of Duty Survivors and CUNY Adjunct employees are not eligible for the** Buy-Out Wavier Program.
- Section I:** Your signature is required in this section to enroll or effect the changes requested on this Application/Change Form.
- Section J:** If you are a NEW retiree (even if you are waiving City coverage), your payroll/personnel office must complete this section.

See top, right-hand corner of reverse side for instructions on submitting this Application/Change Form.  
Retain a copy for your records.

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

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

**RESTRICTIONS:** Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at [www.nyc.gov/olr](http://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\*

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\* 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.