Health Benefits Program

Employee Application/Change Form

www.nyc.gov/olr

Centralized NYCAPS agency/H+H employees ***MUST*** complete the Health Benefits Application through their employee self service.
Non-Centralized agency employees ***MUST*** complete this form and return it to their agency Human Resources Office.
Domestic Partner Changes - Return form to: Health Benefits Program 22 Cortlandt Street, 12th Floor, New York, NY 10007

Please print all information clearly using a black or blue ballpoint pen. See reverse for instructions.

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

A.
- ❑ New Enrollment
- ❑ Reinstatement*
- ❑ Add Optional Benefits*
- ❑ Drop Optional Benefits*
- ❑ Waive Benefits*
- ❑ Buy-Out Waiver Program
  COMPLETE SECTIONS D, E, F & H
  YOU MUST ALSO COMPLETE THE MSC BUY-OUT WAIVER FORM

*Please indicate Effective Date: _____/_____/_____

B. **Change of** (see page 3 for required documentation):
- ❑ Spouse/Domestic Partner: ❑Add ❑Drop
  Effective Date: _____/_____/_____
- ❑ Dependent Child(ren): ❑Add ❑Drop
  Effective Date: _____/_____/_____
- ❑ Change of Name - Former Name:*
  _____
  *Attach legal documents

C. **Transfer of Health Plan and/or Optional Rider Benefits Based on:**
- ❑ Transfer Period
- ❑ Move Into/Out of Health Plan Area
  Effective Date: _____/_____/_____
- ❑ HIP HMO Exemption
- ❑ Transfer after HIP HMO Mandate at Enrollment

D. EMPLOYEE INFORMATION

Last Name:	First Name:	M.I.:	Social Security Number:	Employee Payroll ID#

Home Address:	Apt.:

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

Date of Birth:	Gender: ❑M ❑F ❑N ❑O	Work - Telephone Number:	Mobile\Home - Telephone Number:	E-mail Address:

Marital Status: ❑Single ❑Married ❑Divorced ❑Domestic Partnership ❑Widowed	Date of Event (MM/DD/YY)	Agency/Institution (Name of agency not division):	Union or Welfare Fund:

Name of current City Health Plan:	Name of new City Health Plan (if changing)

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:

Gender: ❑M ❑F ❑N ❑O

Does spouse/domestic partner have City coverage?: ❑Yes ❑No

❑Employed (**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 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 are eligible for individual coverage ***only***. Contact your benefits office for information about family coverage.)

Dependent's Last Name:	Dependent's First Name:	Date of Birth:	Social Security Number:	Gender: M/F/N/O	ADD COVERAGE	DROP COVERAGE	PERMANENTLY DISABLED
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑
					❑	❑	❑

G. HEALTH PLAN ELECTION (Please print clearly)

FULL NAME OF HEALTH PLAN SELECTED: _____

Optional Rider Benefits? (Check "Yes" or "No" for optional rider benefits. If no box is checked, it will be presumed that you do not want optional rider benefits.) ❑Yes ❑No

H. 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. I understand that if I do not complete the MSC Form, I will not be eligible to receive payments. (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 the amount required, if any, through the City Health Benefits Program.

Furthermore, I agree that my 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.

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 Signature: Date:

J. FOR COMPLETION BY AGENCY PAYROLL OR PERSONNEL OFFICE ONLY

I certify that the above employee 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:	Status: ❑ Full-Time ❑ Part-Time ❑ Permanent ❑ Provisional	Pay Period: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Semi-Monthly	Appointment Date: / /	Effective Date of Coverage: / /

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

Print Form | Clear Fields

Instructions for Completing the Health Benefits Application/Change Form

Please refer to the Health Benefits Program Summary of Plan Description (SPD) located on the Program website at nyc.gov/hbp for benefits information and if you should be using Employee Self Service (ESS) or completing this form in order to enroll in or change your health benefits.

Gender Categories:

M - Male/Man
F - Female/Woman
N - Non-binary (Not female/woman or male/man)
0 - Choose not to disclose

Section A: Please complete this section indicating the reason for your submission.

Section B: Please complete this section if you are adding a spouse, domestic partner or dependent child(ren). Refer to the Dependent Eligibility Required Documentation on page 3 of this form or on our website, at nyc.gov/hbp, for a list of all dependent eligibility documentation requirements for health benefits coverage for dependents.

If you are dropping a spouse, domestic partner or dependent child(ren) please submit appropriate documentation, e.g., death certificate, divorce decree, termination of domestic partnership or court order.

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 HIP HMO Exemption if you have submitted a HIP HMO Opt-Out Request Form and the request was approved by EmblemHealth. Attach a copy of the approved form to this application.

Check Transfer after HIP HMO Mandatory Enrollment if you wish to enroll in a new health plan after the 365-day mandatory enrollment period is satisfied.

Section D: Please complete this section with the employee's information ***only***.

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 domestic partner is enrolled in Medicare Parts A & B, you must attach a photocopy of his/her Medicare card.

Domestic Partner Taxation: You should be aware that, under IRS rulings, if your domestic partner is not a 'dependent', within the meaning of the Internal Revenue Code, the amount paid by an employer attributable to coverage of a domestic partner is treated as part of the participant's gross income for Federal tax purposes. Consequently, unless you have indicated and provided proof to the Health Benefits Program (e.g. a copy of a recent tax return) that your domestic partner is your dependent; the value of this benefit must be included as income in your Federal tax return for the applicable year. State and local tax treatment of the amount in question will vary among jurisdictions. You should consult the applicable laws and/or a tax professional to ascertain how the amount should be treated in your case.

Section F: List **ALL** eligible dependent children to be covered.

Section G: Write the complete name of your current health plan or the plan you are selecting (see page 3 of this form for a list of health plans). 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. 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: 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.

Dependent Eligibility Required Documentation

Below is a list of all dependent eligibility documentation requirements for health benefits coverage for adding dependents.

For a Spouse

- married one year or less – Government Issued Marriage Certificate
- married more than one year – Government Issued Marriage Certificate and one of the following:
  - Federal tax return filed within last two years and listing spouse as joint or individual
  - Proof of joint ownership (bank account, auto, home, etc.) issued within last six months
  - Proof of cohabitation (two separate documents – one in your name and one in your spouse's name – at the same address, such as utility bills, bank statements or credit card statements)

For a Domestic Partner

- partnership of one year or less – Domestic Partnership Certificate of Registration
- partnership of more than one year – Domestic Partnership Certificate of Registration and one of the following:
  - Proof of joint ownership (bank account, auto, home, etc.) issued within last six months
  - Proof of cohabitation (two separate documents – one in your name and one in your domestic partner's name – at the same address, such as utility bills, bank statements or credit card statements)

For a Child

NOTE: Disabled status for any child still requires current medical certification from the health plan in addition to the documents listed below.

- Biological Child
  - Government Issued Birth Certificate (including parent's names)

- Step Child – Must be spouse's child. One of the following combinations of documents is required:
  - Government Issued Birth Certificate (including parent's names) and Government Issued Marriage Certificate if married one year or less
  - Government Issued Birth Certificate (including parent's names) and Government Issued Marriage Certificate and Federal tax return filed within last two years listing spouse as joint or individual
  - Government Issued Birth Certificate (including parent's names) and Government Issued Marriage Certificate and proof of joint ownership (bank account, auto, home, etc.) issued within last six months

- Domestic Partner's child – Must be registered domestic partner's child. One of the following combinations of documents is required:
  - Government Issued Birth Certificate (including parent's names) and Domestic Partnership Certificate of Registration if partnership of one year or less
  - Government Issued Birth Certificate (including parent's names) and Domestic Partnership Certificate of Registration and proof of joint ownership (bank account, auto, home, etc.) issued within last six months

- Legal Ward
  - Government Issued Birth Certificate and the court ordered document of legal custody

- Tax Dependent Child
  - Government Issued Birth Certificate and the federal tax return filed in the previous year listing child as dependent

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Health Plans Available to
Employees and their Dependents

Aetna EPO
DC 37 Med-Team (DC 37 members only)
Anthem EPO
Anthem Blue Access Gated EPO
GHI-CBP/Anthem BlueCross BlueShield
GHI HMO
HIP 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/hbp or call the health plans directly.