

Certifying Signature:

## Health Benefits Program Application/Change Form

www.nyc.gov/olr

Employees Return Form to:

Retirees (212) 513-0470 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

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Telephone Number:

## 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 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.