Health Benefits Program
22Cortlandt Street - 12thFloor, New York, NY 10007
(212) 513-0470
www.nyc.gov/olr

Health Benefits Report/Inquiry

Date:_____/_____/_____ ❑ Employee ❑ Retiree ❑ Second Request Employee ID #

Send To:

❑ AETNA EPO ❑ GHI/EBCBS ❑ GHI-HMO ❑ EMPIRE EPO
❑ Empire HMO NY ❑ METROPLUS ❑ VYTRA HEALTH PLANS ❑ HIP PRIME HMO
❑ HIP Prime POS ❑ CIGNA HEALTHCARE ❑ DC37 MED-TEAM ❑ OTHER:_____

REASON(S) FOR SUBMISSION (check one or more boxes)

	Coverage Dates Start	Coverage Dates End	STATUS CHANGE(S)	Date of Event (Effective Date)	STATUS CHANGE(S)	Date of Event (Effective Date)	OTHER
❑ S.L.O.A.C	/ /	/ /	❑ Reinstatement	/ /	❑ Change of Title	/ /	❑ Request ID Cards ❑ Request for Refund
Reason _____			❑ Termination	/ /	❑ Change of Welfare Fund	/ /	❑ Correction of Status ❑ Deduction
❑ FMLA LEAVE COVERAGE	/ /	/ /	❑ Suspension	/ /	❑ Change of Address	/ /	❑ Claims Inquiry Claim # _____
							❑ Other _____

EMPLOYEE INFORMATION

Last Name	First Name	M.I.

Home Address	Apt.

City	State	Zip

EMPLOYEE PAYROLL INFORMATION

Social Security Number	Agency in Which Employed

Agency Code	Pay Period ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Semi-Weekly	Title Code No.	Job Sequence No.

Union or Welfare fund	Present Health Code

EXPLANATION INQUIRY

RESPONSE FROM HEALTH PLAN

By	Department	Telephone Number	Date

PLEASE RETURN ORIGINAL TO AGENCY BENEFITS REPRESENTATIVE INDICATED BELOW

Agency Representative Must Complete this Section:

Name	Title

Agency	Telephone Number

Address

For Employee Benefits Program Use Only:

Reset Fields Print Form

AGENCY BENEFITS REPRESENTATIVE