Health Benefits Program
Retiree Application/Change Form

www.nyc.gov/olr

Submit completed form as follows:
1) Mail: NYC Health Benefits Program
22 Cortlandt Street, 12th Floor New York, NY 10007
2) Electronically: https://nycemployeebenefits.leapfile.net
3) Fax: (212) 306-7373

Please print all information clearly using a black or blue pen. See page 2 for instructions.

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

A.
- ❑ New Retiree Enrollment
- ❑ Disability Retirement
- ❑ Add Optional Benefits*
- ❑ Drop Optional Benefits*
- ❑ Accident Disability Retirement
- ❑ Waive Benefits
- ❑ Reinstatement Benefits

*Indicate effective date: / /

B. Change of:
- ❑ Spouse/Domestic Partner ❑ Add ❑ Drop
- ❑ Dependent Children ❑ Add ❑ Drop
- ❑ Change of Name (attach legal documents)

Former Name*: _____

*Indicate effective date: / /

C. Change of Health Plan Reason:
- ❑ Annual Fall Transfer Period*
- ❑ Retiree Once-in-A- Lifetime
- ❑ Move into/out of Health Plan Area**

**Indicate effective date: / /

*Transfer Period changes are effective January 1.

D. RETIREE INFORMATION

SOCIAL SECURITY NUMBER:	PENSION ID NUMBER:	DATE OF BIRTH: / /	GENDER (SEE REVERSE): ❑M ❑F ❑N ❑O	MARITAL STATUS: ❑SINGLE ❑MARRIED ❑DIVORCED ❑DOMESTIC PARTNERSHIP ❑WIDOWED	DATE OF EVENT (MM/DD/YYYY): / /
LAST NAME:			FIRST NAME:		MI:
ADDRESS (P.O. BOX WILL NOT BE ACCEPTED):					APT.:
CITY:				STATE:	ZIP CODE:
COUNTRY (IF OUTSIDE THE U.S.):	EMAIL ADDRESS:		MOBILE TELEPHONE NUMBER: ( ) -		HOME TELEPHONE NUMBER: ( ) -
NAME OF CURRENT CITY HEALTH PLAN (IF CHANGING):	MBI NUMBER (FROM MEDICARE CARD):	Are you Medicare eligible? ❑Yes ❑No If YES, Please attach a copy of his/her Medicare card to this application			**ATTACH COPY OF MEDICARE CARD**
AGENCY IN WHICH RETIRED FROM:	NAME OF UNION OR WELFARE FUND:	PENSION SYSTEM/ANNUITY FUND* (CHECK ONE): ❑BERS ❑FIRE ❑NYCERS ❑POLICE ❑TIAA ❑TRS *Members of the VDC Program are not eligible for retiree health benefits.			

E. SPOUSE/DOMESTIC PARTNER - ONLY COMPLETE IF YOUR SPOUSE/DOMESTIC PARTNER IS TO BE COVERED. IF NOT, LEAVE BLANK.

LAST NAME (AS IT APPEARS ON YOUR MEDICARE CARD, IF APPLICABLE):		Is spouse/domestic partner employed by the City? ❑Yes ❑No (DOUBLE CITY COVERAGE NOT PERMITTED) If YES please indicate the name of the agency spouse is employed by in the space below.	
FIRST NAME (AS IT APPEARS ON YOUR MEDICARE CARD, IF APPLICABLE):	M.I.:	DATE OF BIRTH: / /	NAME OF CITY AGENCY:
SOCIAL SCURITY NUMBER:	MBI NUMBER (FROM MEDICARE CARD):	GENDER (SEE REVERSE): ❑M ❑F ❑N ❑O	Is spouse/domestic partner Medicare eligible? ❑Yes ❑No If YES, Please attach a copy of his/her Medicare card to this application — **ATTACH COPY OF MEDICARE 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.

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

DEPENDENT LAST NAME'S	DEPENDENT FIRST NAME'S	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER M/F/N/O	ADD COVERAGE	DROP COVERAGE	PERMAMENTLY DISABLED**
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑

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Retain a copy for your records.

Instructions for Completing the Retiree Health Benefits Application/Change Form

Gender Categories:

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

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 file the Retiree Health Benefits Application for continuation of coverage into retirement with your agency personnel office prior to retirement (ideally provide 6 to 8 weeks notice), coverage begins on the day of retirement for most retirees. Employees who had previously waived coverage can enroll in Retiree Health Benefits upon retirement. Retirees who wish to continue to waive City health benefits must complete a new Retiree Health Benefits Application selecting to Waive Benefits. The effective date of the reinstatement will be the date of retirement, or the first day of the month following the processing of the this application. An enrollment is considered late if an application is submitted more than 30 days after the event that made the retiree or dependent eligible. In cases of late enrollment, coverage will begin on the first day of the month following the processing of this application.

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: 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 4 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 Annual Fall Transfer Period. (Changes will be effective January 1st.)

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. (Note: You can only use this option after being retired for one full year.)

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.

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. If a dependent child is permanently disabled, and on Medicare, you must attach a photocopy of his/her Medicare card. Visit OLR's website at nyc.gov/hbp for health plan rate information.

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: Your signature is required in this section to enroll or effect the changes requested on this Form.

Section I: If you are a NEW retiree (even if you are waiving City coverage), your payroll/personnel office must complete this section. If you are newly retired from H+H, CUNY TIAA or an eligible MTA City title, you must submit the appropriate document for adding a dependent.

G. HEALTH PLAN ELECTION - FOR HEALTH PLAN INFORMATION AND RATES, VISIT NYC.GOV/HBP

Place an "X" in the box next to the plan you choose to join. Select only one plan: if more than one plan is selected, your transfer request will not be processed.

NON-MEDICARE PLANS		*MEDICARE SUPPLEMENTAL PLANS*
❑ Aetna EPO	❑ GHI HMO	❑ DC 37 Med-Team Senior Care
❑ Cigna Healthcare	❑ HIP Prime HMO	❑ Empire Medicare-Related Coverage
❑ DC 37 Med-Team (DC 37 members only)	❑ HIP Prime POS	❑ GHI/EBCBS Senior Care
❑ Empire EPO	❑ MetroPlus Gold	❑ GHI HMO Medicare Senior Supplement
❑ Empire Gated EPO	❑ Vytra Health Plans	
❑ GHI-CBP/Empire BlueCross BlueShield		

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

MEDICARE HMOS & ADVANTAGE PLANS - YOU MUST HAVE MEDICARE PARTS A & B
(Contact the health plan directly for a special Medicare HMO Enrollment Form- the form must be returned directly to the health plan.)

Place an "x" in the box next to the plan you choose to join. You must complete and submit this form, as well as contact the Medicare HMO directly, to request a special enrollment form. The special enrollment form must be returned directly to the health plan. (If you are presently enrolled in a Medicare HMO and are transferring to a Medicare Supplemental Plan, you must first disenroll from your current plan.) Please also attach a copy of the special enrollment or disenrollment form to this application.

❑ AvMed Medicare Plan ❑ Aetna Medicare PPO Plan ❑ Cigna HealthSpring ❑ Elderplan ❑ Empire MediBlue
❑ Humana Gold Plus ❑ HIPVIP Premier Medicare Plan ❑ United HealthCare Group Medicare Advantage Plan

H. 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 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.

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.

Retiree's Signature: _____ Date: _____

I. FOR COMPLETION BY PAYROLL OR PERSONNEL OFFICE ONLY

I certify that the above retiree is eligible for the New York City Health Benefits Program (HBP) and that dependent documentation has been verified in accordance with HBP procedures.

AGENCY CODE:	TITLE CODE:	STATUS: ❑FULL-TIME ❑PART-TIME	RETIREMENT DATE: / /	EFFECTIVE DATE OF COVERAGE: / /	
PENSION SYSTEM:		YEARS OF CREDITED SERVICE:	CITY START DATE: / /	PENSION NUMBER:	
CERTIFYING SIGNATURE:				DATE: / /	TELEPHONE NUMBER: ( ) -

Print Form Clear Fields

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