Health Benefits Program
Retiree Application/Change Form

www.nyc.gov/hbp

Submission Instructions:
Secure Electronic Upload:
https://nycemployeebenefits.leapfile.net
Fax: (212) 306-7373
Mail: NYC Health Benefits Program
22 Cortlandt Street, 12th Floor, New York, NY 10007
Note: Retirees of New York Public Library, Brooklyn Public Library and cultural institutions, submit your application directly to your benefits office.

Please refer to the Health Benefits Program Summary Program Description (SPD) available at nyc.gov/hbp for enrollment eligibility for City health benefits as a retiree before completing this application. See page 2 for form instructions.

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

A. Enrollment:

- ❑ New Retiree
- ❑ Disability Retirement
- ❑ Accident Disability Retirement
- ❑ Annual Fall Transfer Period (Effective January 1)
- ❑ Use Retiree Once-In-A-Lifetime
- ❑ Reinstatement of Retiree Health Benefits
- ❑ Waive Retiree Health Benefits (includes covered dependents)
- ❑ New Health Plan due to move into/out of Health Plan Area

Effective date is subject to change based on Plan administrative procedures.

B. Change of:

- ❑ Spouse/Domestic Partner ❑ Add ❑ Drop
- ❑ Dependent Children ❑ Add ❑ Drop
- ❑ Change of Name (attach legal documents) ❑ Self ❑ Dependent
  New Name: _____ Effective date: ___/___/___
  Former Name: _____
- ❑ Address (Enter new address in C below) - Effective Date: ___/___/___
- ❑ Optional Prescription Drug Benefits ❑ Add ❑ Drop
- ❑ 365-Day Rider Benefits (GHI Senior Care Only) ❑ Add ❑ Drop
- ❑ Rider Other (HIP HMO Only) ❑ Add ❑ Drop

C. 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: (PLEASE CHECK THIS BOX IF THIS IS A NEW ADDRESS: ❑)					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, ATTACH COPY OF MEDICARE CARD**
AGENCY YOU ARE RETIRING 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.			

D. FAMILY INFORMATION (Attach a second form if necessary.) Visit OLR's website at nyc.gov/hbp for health plan rate information.
Note: If your spouse/domestic partner is employed by the City or a participating employer, double City coverage is not permitted. In addition, dependents may not be covered under two NYC Health Plans.

List your spouse/domestic partner to be covered and all eligible dependent children.
Indicate if you are adding or dropping coverage by checking the appropriate box below.

****Attach a copy of Medicare card for your Medicare eligible spouse/domestic partner and/or disabled dependent, if applicable.**

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

Instructions for Completing the Retiree Health Benefits Application/Change Form

Gender Categories: **M** - Male/Man **F** - Female/Woman **N** - Non-binary (Not M or F) **O** - Choose not to disclose

Section A: If you are a NEW retiree, you should only select from the following: Retirement Enrollment, 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 6 to 8 weeks in advance), coverage begins on the day of retirement for most retirees. Employees who had previously waived coverage can enroll in Retiree Health Benefits upon retirement. New retirees who wish to continue to waive City health benefits in retirement must complete this application, selecting Waive Retirement Health Benefits. The effective date of the reinstatement will be the date of retirement, or the first day of the month following the processing of 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.

Check New Health Plan due to 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 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., proof of other health coverage, death certificate, divorce decree, termination of domestic partnership or court order. Note: They may be eligible for COBRA (please see website for details and application).

If changing your name, please indicate your former name and provide documentation of name change.

Check Annual Fall Transfer Period if the change you are requesting, such as adding optional benefits or changing plans, is being made during an Annual Fall Transfer Period. (Changes will be effective January 1st.)

Section C: If you are enrolled in Medicare Parts A & B, you must attach a photocopy of your Medicare card.

Section D: List your spouse/domestic partner to be covered. If your spouse/domestic partner is enrolled in Medicare Parts A & B, you must attach a photocopy of their Medicare card.

List **ALL** eligible dependent children to be covered. If a dependent child is permanently disabled and on Medicare, you must attach a photocopy of their Medicare card.

If your spouse/domestic partner is employed by the City or a participating employer, double City coverage is not permitted. In addition, dependents may not be covered under two NYC Health Plans.

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 on 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 E: Select only one health plan. Please see the rate chart and SPD for health plan costs, optional rider benefits and service areas before selecting a plan. If you do not make an optional rider selection, you will be given basic coverage only.

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

Section G: 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.

RETIREE'S LAST NAME:_____ **SSN (LAST 4 DIGITS):** _____

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

Check the box next to the plan you choose to join. **Select only <u>one</u> health plan. Refer to the Summary of Plans section of the SPD for detailed plan information. Please see the rate chart and SPD for health plan costs, optional rider benefits and service areas before selecting a health plan.**

NON-MEDICARE PLANS (UNDER AGE 65 & NOT MEDICARE ELIGIBLE)

- ❑ Aetna EPO (nationwide)
- ❑ Anthem EPO (nationwide)
- ❑ Anthem Gated EPO (NY, NJ and CT)
- ❑ GHI HMO (certain NYS counties only)
- ❑ HIP HMO Preferred
- ❑ HIP Prime POS (certain NYS counties only)
- ❑ MetroPlus Gold (all five NYC boroughs)
- ❑ NYCE PPO
- ❑ DC 37 Med-Team (**DC 37 members only**: No Optional Rider - Basic Only)
- ❑ Vytra Health Plans (Queens, Nassau & Suffolk counties only)

<u>Optional Rider Options:</u>

- ❑ Check here for *Optional Rider Benefits:* (If the box is **not** checked, it will be presumed that you do not want Optional Rider Benefits.)
- ❑ Check here for *Rider Other Benefits* for HIP HMO Preferred only. (If the box is **not** checked, it will be presumed that you do not want Rider Other Benefits.)

MEDICARE SUPPLEMENTAL PLANS - YOU MUST HAVE MEDICARE PARTS A & B (AGE 65+ OR MEDICARE ELIGIBLE)

- ❑ Anthem Medicare-Related Coverage
- ❑ DC 37 Med-Team Senior Care (DC 37 members only: No Optional Rider - Basic Only)
- ❑ GHI/Anthem Senior Care
- ❑ GHI HMO Medicare Senior Supplement (certain NYS counties only)

<u>Optional Rider Options:</u>

- ❑ Check here for *Optional Rider Benefits** (If the box is **not** checked, it will be presumed that you do not want Optional Rider Benefits.)
- ❑ 365-Day Rider Benefits (for GHI/Anthem Senior Care only)*

*Prescription drug coverage Based on Union Welfare Fund eligibility. Check with your union or welfare fund or your non-City Medicare Part D plan to determine if you have Medicare-creditable prescription drug coverage.

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.)

Check the box next to the plan you choose to join. If your Union Welfare Fund eligibility does not provide Medicare-creditable prescription drug coverage, you will automically be enrolled in the optional rider prescription drug plan through the health plan you select below.

IMPORTANT: 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.

- ❑ Aetna Medicare PPO Plan
- ❑ Anthem Medicare Preferred (PPO)
- ❑ HIPVIP Premier Medicare Plan
- ❑ Humana Gold Plus (FL Only)
- ❑ United HealthCare Group Medicare Advantage Plan (NY and NJ)

F. 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 health premiums from my pension for the amount required, if any. I understand that my New York City health plan will be coordinated with those available through Medicare, Medicaid or other health plans.

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: _____

G. FOR COMPLETION BY AGENCY 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: / /	EMAIL ADDRESS:	
CERTIFYING SIGNATURE:				DATE: / /	TELEPHONE NUMBER: ( ) -

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 90 days
  - Proof of cohabitation (two separate documents – one in your name and one in your spouse's name – at the same address, such as recurring monthly household bills or statement of account)

For a Domestic Partner

- Partnership of one year or less – Government issued Certificate of Domestic Partnership
- 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 the last 90 days
  - Proof of cohabitation (two separate documents – one in your name and one in your domestic partner's name – at the same address, such recurring monthly household bills or statement of account)

For a Child

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

- Step Child – Must be spouse's child. One of the following combinations of documents is required:
  - Government-Issued Birth Certificate (including parents' names) and Government-Issued Marriage Certificate if married one year or less
  - Government-Issued Birth Certificate (including parents' 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 90 days

- Domestic Partner's child – Must be the registered domestic partner's child. One of the following combinations of documents is required:
  - Government-issued Birth Certificate (including parents' 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 90 days

- 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 the child as a dependent

NOTE: Continuation of coverage for a disabled child age 26 or older requires current medical certification from the health plan in addition to the documents listed above.