York College
The City University of New York
94-20 Guy R. Brewer Blvd., Jamaica, NY 11451
Office of Human Resources
Main Number: 718 262-2135 Fax: 718 262-2143

NEW FACULTY, ECP, CLT, & NON-INSTRUCTIONAL STAFF BENEFITS CHECKLIST

Please complete the following documents and return to Human Resources to expedite processing your Health, Welfare Fund and Pension Plan Benefits.

Medical Coverage

_____ Health Benefits Application
_____ Spouse – Marriage Certificate required
_____ Additional proof if married for more than one year, *see attachment*
_____ Child(ren) – Birth Certificate (s) required
_____ Domestic Partner – Provide a copy of your Domestic Partnership Certificate
_____ Entered Medical Plan – PayServ

Prescription, Dental & Optical Benefits

_____ PSC-CUNY Welfare Fund Enrollment Card

Life Insurance

_____ Death Benefits Beneficiary Designation Card

Retirement Plan Election Form – choice of two pension plan options

_____ Signed Notice of Eligibility form
_____ Optional Retirement Program (TIAA-CREFF) Application – if you are a past or current Member of TIAA-CREFF provide your membership numbers – enter in Pay Serv (Deduction/Retirement)
_____ TIAA-CREFF Action Request form (if applicable)
_____ Teachers' Retirement System (TRS) of New York - Enroll online – if you are a past or current Member of TRS provide your membership number
_____ Designation of Beneficiary(ies) and Social Security Number(s)

Voluntary Benefits

_____ Transit Benefit - Edenred
_____ Flexible Spending Accounts Program

Incomplete or missing information on your required forms will delay your enrollment process. If you have any questions or need assistance, please contact Brigette Major, Human Resources Benefits Specialist at 718 262-2076.

_____ _____
Employee's Name Date

Health Benefits Program
Application/Change Form

www.nyc.gov/olr

Employees Return Form to:	Retirees (212) 513-0470 Return Form to:	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

Please print all information clearly using a black or blue ballpoint pen.

Applicant MUST check one: ☑ **EMPLOYEE** ☐ **RETIREE** ☐ **RETURN TO RETIREMENT (Check this box if you were previously retired)** ☐ **LINE OF DUTY SURVIVOR**

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

A.
- ☑ New Enrollment
- ☐ Reinstatement*
- ☐ Retirement
- ☐ Disability Retirement*
- ☐ Accident Disability Retirement
- ☐ Drop Optional Benefits*
- ☐ Add Optional Benefits*
- ☐ Waive Benefits*

EMPLOYEES ONLY:
- ☐ Buy-Out Waiver Program
  COMPLETE SECTIONS D, E, F & H

*Please indicate Effective Date: _____/_____/_____

B. Change of:
- ☐ Spouse/Domestic Partner: ☐ Add ☐ Drop
  Effective Date: _____/_____/_____
- ☐ Dependent Child(ren): ☐ Add ☐ Drop
  Effective Date: _____/_____/_____
- ☐ Change of Name - Former Name:
  _____

C. Transfer of Health Plan and/or Optional/Benefit Based on:
- ☐ Transfer Period
- ☐ Move Into/Out of Health Plan Area
  Effective Date: _____/_____/_____
- ☐ Retiree Once-in-A-Lifetime
  Effective Date: _____/_____/_____

D. EMPLOYEE/RETIREE INFORMATION

Last Name:	First Name:	M.I.:	Social Security Number:

Home Address: | Apt.:

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

Date of Birth: | Sex: ☐M ☐F | Work - Telephone Number: | Mobile\Home - Telephone Number: | E-mail Address:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partnership | Date of Event (MM/DD/YY) | Agency in which employed or retired from: York College | Union or Welfare Fund: PSC CUNY

Name of current City Health Plan:

Are you Medicare eligible: ☐Yes ☐No
If YES, please attach a copy of your Medicare card to this application.

ATTACH COPY OF CARD

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:

Sex: ☐M ☐F

Is spouse/domestic partner: ☐Employed (**Double City coverage is not permitted**) ☐Retired (**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 spouse/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 EMPLOYEES: CITY RATES APPLY FOR INDIVIDUAL COVERAGE ***ONLY***. CONTACT YOUR BENEFITS OFFICE FOR INFORMATION ABOUT ADDITIONAL COST FOR FAMILY COVERAGE.)

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

Dependent's Last Name:	Dependent's First Name:	Date of Birth:	Social Security Number:	Sex: M/F	ADD COVERAGE	DROP COVERAGE	PERMANENTLY DISABLED*
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☑
					☐	☐	☐

G. HEALTH PLAN REQUESTED (Please print clearly)

FULL NAME OF HEALTH PLAN SELECTED: _____

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

H. EMPLOYEES ONLY (RETIREES ARE INELIGIBLE 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. (Retirees, 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/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.

Furthermore, I agree that my periodic 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. (Section 125 does not apply to retirees.)

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/Retiree Signature: N0 | Date:

J. FOR COMPLETION BY PAYROLL OR PERSONNEL OFFICE ONLY

I certify that the above employee/retiree 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 No.:	Status: ☐Full-Time ☐Part-Time ☐Permanent ☐Provisional	Appointment/Retirement Date:	Pay Period: ☐Weekly ☐Bi-Weekly ☐Monthly ☐Semi-Monthly	Effective Date of Coverage:

Retirement System (For Retiring Employees):	Years of Credited Service:	City Start Date:	Retirement Date:	Pension Number:

Certifying Signature:	Date:	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.

EMPLOYEE Health Plan Rates as of July 2022 (Rates are subject to change)

These rates are in effective July 1, 2022 and will be reflected as of your first full payroll period in July 2022

WEEKLY

INDIVIDUAL	Aetna EPO	CIGNA	DC37 Med Team	Empire Blue Access Gated EPO	Empire EPO	GHI-CBP/EBCBS	GHI HMO	HIP HMO Gold Preferred Plan Grandfathered (closed to new enrollments)	HIP HMO Gold Preferred Plan Standard	HIP POS	MetroPlus Gold Grandfathered (closed to new enrollments)	MetroPlus Gold Standard	Vytra
Basic	$103.38	$243.07	$0.00	$91.29	$223.74	$0.00	$59.67	$0.00	$0.00	$258.26	$0.00	$0.00	$47.31
Prescription Drugs	$489.12	$75.92	$0.00	$91.15	$91.15	$17.51	$106.68	$77.15	$35.13	$85.65	$64.20	$31.97	$90.97
Rider Other*	$0.00	$0.00	$0.00	$0.00	$0.00	$0.95	$0.00	$2.23	$2.23	$0.00	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$592.49**	**$318.99**	**$0.00**	**$182.44**	**$314.90**	**$18.46**	**$166.36**	**$79.38**	**$37.36**	**$343.91**	**$64.20**	**$31.97**	**$138.28**

FAMILY	Aetna EPO	CIGNA	DC37 Med Team	Empire Blue Access Gated EPO	Empire EPO	GHI-CBP/EBCBS	GHI HMO	HIP HMO Gold Preferred Plan Grandfathered (closed to new enrollments)	HIP HMO Gold Preferred Plan Standard	HIP POS	MetroPlus Gold Grandfathered (closed to new enrollments)	MetroPlus Gold Standard	Vytra
Basic	$424.20	$655.99	$0.00	$267.52	$569.58	$0.00	$171.99	$0.00	$0.00	$632.74	$0.00	$0.00	$161.14
Prescription Drugs	$1,383.38	$229.77	$0.00	$223.47	$223.47	$32.10	$272.07	$189.02	$64.41	$209.85	$160.50	$58.41	$236.66
Rider Other*	$0.00	$0.00	$0.00	$0.00	$0.00	$2.41	$0.00	$5.46	$5.46	$0.00	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$1,807.59**	**$885.77**	**$0.00**	**$490.99**	**$793.05**	**$34.51**	**$444.07**	**$194.48**	**$69.87**	**$842.58**	**$160.50**	**$58.41**	**$397.80**

*** For GHI-CBP/EBCBS, "Rider Other" is for enhanced major medical coverage. For HIP HMO, "Rider Other" is for private duty nursing & durable medical equipment.**

****Please note that effective August 1 2021 the grandfathered rider will be closed and the only rider available will be the standard rider.**

BI-WEEKLY

INDIVIDUAL	Aetna EPO	CIGNA	DC37 Med Team	Empire Blue Access Gated EPO	Empire EPO	GHI-CBP/EBCBS	GHI HMO	HIP HMO Gold Preferred Plan Grandfathered (closed to new enrollments)	HIP HMO Gold Preferred Plan Standard	HIP POS	MetroPlus Gold Grandfathered (closed to new enrollments)	MetroPlus Gold Standard	Vytra
Basic	$206.75	$486.14	$0.00	$182.58	$447.48	$0.00	$119.34	$0.00	$0.00	$516.52	$0.00	$0.00	$94.63
Prescription Drugs	$978.23	$151.84	$0.00	$182.31	$182.31	$35.02	$213.37	$154.30	$70.26	$171.30	$128.40	$63.95	$181.94
Rider Other*	$0.00	$0.00	$0.00	$0.00	$0.00	$1.91	$0.00	$4.46	$4.46	$0.00	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$1,184.98**	**$637.98**	**$0.00**	**$364.89**	**$629.79**	**$36.92**	**$332.71**	**$158.76**	**$74.71**	**$687.82**	**$128.40**	**$63.95**	**$276.56**

FAMILY	Aetna EPO	CIGNA	DC37 Med Team	Empire Blue Access Gated EPO	Empire EPO	GHI-CBP/EBCBS	GHI HMO	HIP HMO Gold Preferred Plan Grandfathered (closed to new enrollments)	HIP HMO Gold Preferred Plan Standard	HIP POS	MetroPlus Gold Grandfathered (closed to new enrollments)	MetroPlus Gold Standard	Vytra
Basic	$848.41	$1,311.99	$0.00	$535.04	$1,139.16	$0.00	$343.98	$0.00	$0.00	$1,265.48	$0.00	$0.00	$322.27
Prescription Drugs	$2,766.77	$459.55	$0.00	$446.94	$446.94	$64.20	$544.15	$378.04	$128.81	$419.69	$321.00	$116.82	$473.32
Rider Other*	$0.00	$0.00	$0.00	$0.00	$0.00	$4.82	$0.00	$10.93	$10.93	$0.00	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$3,615.18**	**$1,771.53**	**$0.00**	**$981.98**	**$1,586.10**	**$69.02**	**$888.13**	**$388.97**	**$139.74**	**$1,685.17**	**$321.00**	**$116.82**	**$795.60**

*** For GHI-CBP/EBCBS, "Rider Other" is for enhanced major medical coverage. For HIP HMO, "Rider Other" is for private duty nursing & durable medical equipment.**

****Please note that effective August 1 2021 the grandfathered rider will be closed and the only rider available will be the standard rider.**

SEMI-MONTHLY

INDIVIDUAL	Aetna EPO	CIGNA	DC37 Med Team	Empire Blue Access Gated EPO	Empire EPO	GHI-CBP/EBCBS	GHI HMO	HIP HMO Gold Preferred Plan Grandfathered (closed to new enrollments)	HIP HMO Gold Preferred Plan Standard	HIP POS	MetroPlus Gold Grandfathered (closed to new enrollments)	MetroPlus Gold Standard	Vytra
Basic	$224.60	$528.10	$0.00	$198.34	$486.11	$0.00	$129.65	$0.00	$0.00	$561.11	$0.00	$0.00	$102.80
Prescription Drugs	$1,062.67	$164.95	$0.00	$198.05	$198.05	$38.04	$231.79	$167.62	$76.32	$186.09	$139.49	$69.47	$197.64
Rider Other*	$0.00	$0.00	$0.00	$0.00	$0.00	$2.07	$0.00	$4.84	$4.84	$0.00	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$1,287.26**	**$693.05**	**$0.00**	**$396.38**	**$684.15**	**$40.11**	**$361.43**	**$172.46**	**$81.16**	**$747.19**	**$139.49**	**$69.47**	**$300.44**

FAMILY	Aetna EPO	CIGNA	DC37 Med Team	Empire Blue Access Gated EPO	Empire EPO	GHI-CBP/EBCBS	GHI HMO	HIP HMO Gold Preferred Plan Grandfathered (closed to new enrollments)	HIP HMO Gold Preferred Plan Standard	HIP POS	MetroPlus Gold Grandfathered (closed to new enrollments)	MetroPlus Gold Standard	Vytra
Basic	$921.64	$1,425.23	$0.00	$581.22	$1,237.49	$0.00	$373.67	$0.00	$0.00	$1,374.70	$0.00	$0.00	$350.09
Prescription Drugs	$3,005.57	$499.21	$0.00	$485.52	$485.52	$69.75	$591.12	$410.67	$139.93	$455.92	$348.71	$126.90	$514.18
Rider Other*	$0.00	$0.00	$0.00	$0.00	$0.00	$5.24	$0.00	$11.87	$11.87	$0.00	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$3,927.20**	**$1,924.44**	**$0.00**	**$1,066.73**	**$1,723.00**	**$74.98**	**$964.79**	**$422.54**	**$151.80**	**$1,830.62**	**$348.71**	**$126.90**	**$864.27**

*** For GHI-CBP/EBCBS, "Rider Other" is for enhanced major medical coverage. For HIP HMO, "Rider Other" is for private duty nursing & durable medical equipment.**

****Please note that effective August 1 2021 the grandfathered rider will be closed and the only rider available will be the standard rider.**

Enrollment Form

PSC-CUNY Welfare Fund
61 Broadway, 15th Floor
New York, NY 10006
Office: 212-354-5230 Fax: 212-354-5363
Website: www.psccunywf.org

Required

A copy of your NYC Health Benefits Application is required and/or WF Domestic Partner form if Applicable.

Dependent information will be obtained from your NYC Health Application unless you indicate otherwise.

Member

NYSUT ID: _____ NYS ID (State Colleges): N0

Social Security: _____ Date of Birth: ___/___/___

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Marital Status: ☐ S ☐ M ☐ DP Gender: ☐ F ☐ M

Primary Telephone: (___) _____ Primary Email: _____

Dental

For more information visit: www.psccunywf.org

Guardian PPO ✔

DeltaCare USA HMO ☐ **Delta will assign you a Dentist. To change it, call Delta or go Online.*

Health Plan

GHI CBP — Basic ☐ Rider ✔ Waived ☐ Stipend ☐

Waive ALL Benefits: Rx, Dental, Vision, Hearing Aid ☐

Member

I hereby certify that all of my personal information presented here is true and accurate.

Signature _____ Date

College

_____ Effective Date of Coverage: ___/___/___

CUNY Campus

_____ Effective Date of Hire: ___/___/___

Job Title and Code

Earliest CUNY Hire Date: ___/___/___

If Classified Managerial check here ☐

_____ Previous College (if applicable)

I hereby certify to the best of my knowledge that the information presented here is accurate, complete and sufficient to verify eligibility for benefits under the PSC-CUNY Welfare Fund.

Benefits Officer _____ Date _____

[PSC-CUNY Welfare Fund Use Only] [Alpha]

Date Received Authorization Initials Date

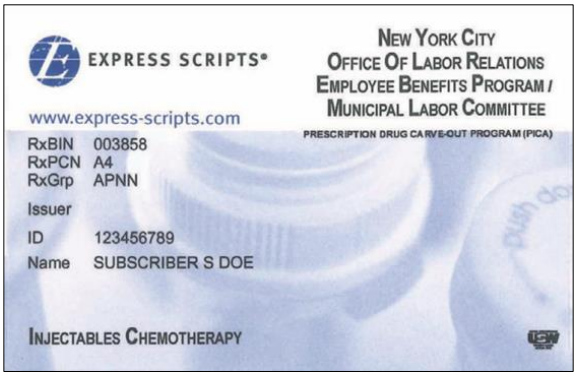
Prescriptions and Your PSC-CUNY Welfare Fund Coverage:

Three cards you may need at your pharmacy

Employees and non-Medicare retirees* who are enrolled in the PSC-CUNY Welfare Fund prescription plan may have three different cards to use when filling prescriptions. Depending on your medications, you should be prepared to present **all three cards** at the pharmacy. Which card should you use and when? Take a look:

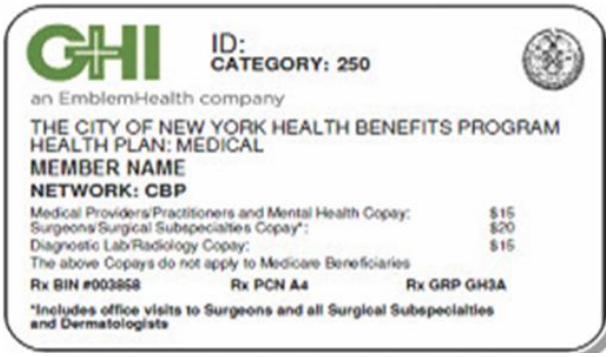
1) For **most prescriptions** use the PSC-CUNY Welfare Fund CVS/Caremark prescription drug card. You can use the CVS/Caremark card at any pharmacy—CVS, Duane Reade, Rite Aid, Walgreens, etc.

2) For **injectable and chemotherapy prescriptions**, use the NYC PICA Program Express Scripts prescription drug card. Don't have a PICA card? Call 212-306-7464.



3) For **diabetes-related prescriptions and supplies**, use your NYC HBP basic health insurance card (GHI, HIP-HMO, Empire, Aetna, CIGNA, etc.)

GHI members also use their GHI card for preventive medications, including contraceptives, vaccines and colonoscopy preparation drink. A complete list of preventive medications covered by GHI is available on the Welfare Fund website, psccunywf.org.



When in doubt, be prepared to present each of these prescription drug cards. If the pharmacist says your medication is not covered by one of them, it may be covered by another. If you have questions, please call CVS/Caremark customer care, 866-209-6177.

*Retirees enrolled in Medicare use the PSC-CUNY Welfare Fund SilverScript Medicare Part D drug card for all covered prescription medications.

Death Benefit Beneficiary Designation Card

Name of Employee
(Last) (First) Middle Initial

Social Security Number	Male ☐ Female ☐	Date of Birth Mo. Day Yr. 19

Name of College:

Date employed: Job title

Primary Beneficiary Name Telephone number
relation to me

Primary Beneficiary Address,

Contingent Beneficiary Name Telephone number
relation to me

Contingent Beneficiary Address,

Date Signed Signature of Employee
Mo. Day Yr.

Order of Payment and Division of Benefits. Unless otherwise provided:

(a) Payment at my death is to be made to a primary beneficiary if he/she is then living.

(b) Payment at my death is to be made to a contingent beneficiary if he/she is then living and there is no primary beneficiary then living.

(c) If all beneficiaries predecease me, the benefits will be payable to my estate.

How to enroll

Enrollment eligibility and details for the CUNY Optional Retirement Program (ORP)

You have 30 days after the date of your hire to enroll. All full-time faculty and professional members (teaching and nonteaching or executive compensation plan employees) are eligible to choose between two plans: the NYC Teachers' Retirement System (TRS) Defined Benefit Plan or the Optional Retirement Program offered through TIAA. If you do not choose a plan within 30 days of employment, you will be automatically default enrolled into the Defined Benefit Plan.

Contribution information for the Optional Retirement Program

The City University of New York (CUNY) requires appointed members to contribute a certain percentage of base salary through regular payroll deductions as a condition of employment.

- CUNY contributes 8% of your salary for the first seven years of your employment and 10% for all subsequent years.
- New employees are required to contribute 3%-6% (pretax) of your salary through regular payroll deductions. See contribution table below:

Wages up to $45,000	3%
Wages $45,000.01 and up to $55,000	3.5%
Wages $55,000.01 and up to $75,000	4.5%
Wages $75,000.01 and up to $100,000	5.75%
Wages $100,000.01 and greater	6%

- Once you have completed 366 days of service with CUNY, you are fully vested in all retirement and death benefits provided by the investments purchased through both the University and your own contributions. The 366-day wait is waived for employees who enter service with a current, pre-existing vested TIAA retirement contract.

To learn more, visit TIAA.org/cuny.

Don't forget to join the CUNY Voluntary Savings Plan. Open a Tax-Deferred Annuity.

Contributing to a Tax-Deferred Annuity (TDA) can help you supplement the retirement income you can receive from your retirement plan and Social Security.

The TDA Plan allows you to make pretax and Roth (after-tax) contributions to your retirement savings.

The major difference between a Roth contribution option and a pretax contribution option is *when* you pay income taxes. With a pretax option, your contribution comes out of your paycheck before it is taxed. Pretax contributions lower your taxable income in the year of your contribution, and your contributions and earnings are tax deferred until you take them out of your TDA Plan account. With the Roth contribution option, your contribution is taken out of your paycheck after taxes are paid. Roth contributions do not lower your current taxable income. Your Roth contributions, and the accumulations on them, are not taxed when qualified withdrawals are made.*

Instructions on how to enroll are on next page.

Enrolling with the CUNY Optional Retirement Program

Remember, you have only 30 days to make the choice that's right for you. After that, you will be automatically default enrolled into the NYC Teachers' Retirement System (TRS) Defined Benefit Plan, which is irrevocable.

For information on enrollment eligibility and details on the CUNY Optional Retirement Program and Tax-Deferred Annuity Plan offered, please visit **TIAA.org/cuny**.

Before you begin to enroll, have handy your Social Security number, birth date and address, along with the same information for your beneficiary if you'd like to name one at this time.

Enrolling online is fast and simple:

Visit TIAA.org/cuny

- Select *Ready to Enroll.*
- Choose *Optional Retirement Program* (Employer Program) and then *Next.*
- Click *Begin Enrollment.*
- Arrive at the TIAA *Welcome* page where you can register for a user ID and password or enter your log-in information if you are already registered with TIAA.
- Enter your user ID and click *Log In* if you are a returning user.
- Or, click *Register with TIAA* if you are a first-time user.
- Select your school from the drop-down list.
- Follow the on-screen instructions. You will be asked for specific investment choices on the Allocation screen.
- When you arrive at the *Thank You* screen, your online enrollment is complete.
- You may want to print a copy of the confirmation for your records.

To enroll in the Tax-Deferred Annuity Plan visit TIAA.org/cuny.

You will need to enroll in the TDA Plan and then complete a Salary Reduction Agreement (SRA), which allows you to set up contributions directly from your paycheck to your retirement account. Return your completed SRA form and proof of enrollment to your campus benefits office. Federal law allows tax deferred savings up to $18,000 in 2017 and if you will be age 50 or over in 2017, you may contribute an additional $6,000 in 2017, for a maximum of $24,000.

CUNY has dedicated representatives at TIAA who are trained to answer all of your questions about the retirement plan. Call **800-842-2252** to be connected with a representative. To schedule an in-person advice session with your dedicated financial consultant, go to **TIAA.org/schedulenow** and sign up. Or you may meet with your financial consultant at one of the following offices:

New York Financial Center
750 Third Avenue
(Between 46th & 47th Sts)
New York, NY 10017-3206

Long Island Office
58 South Service Road, Suite 305
Melville, NY 11747

*Withdrawals of earnings prior to age 59½ are subject to ordinary income tax, and a 10% penalty may apply. Earnings can be distributed tax free if distribution is no earlier than five years after contributions were first made and you meet at least one of the following conditions: Age 59½ or older or permanently disabled. Beneficiaries may receive a distribution in the event of your death.

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PSCcuny /

Professional Staff Congress / City University of New York
61 Broadway, Suite 1500 • New York, New York 10006 • 212/354-1252 • Fax 212/302-7815
Visit our website at http://www.psc-cuny.org

CHOOSING A PENSION PLAN: A GUIDE FOR NEW MEMBERS (Tier VI)

New York State law mandates participation in a retirement system for full-time members of the instructional staff. New staff members have 30 days from the effective date of their appointment to choose a retirement program, and the choice is irrevocable. If no choice is filed within 30 days, the law mandates that the member be assigned to the New York City Teachers' Retirement System (TRS).

Full-time instructional staff members must choose between the New York City Teachers' Retirement System (TRS) and the Optional Retirement Program (ORP). Those who elect the Optional Retirement Program must choose investment options through either Teachers Insurance and Annuity Association-College Retirement Equities Fund (TIAA-CREF) or through the alternate funding vehicles offered by Guardian or MetLife. More information may be obtained from your college HR Office.

Adjuncts employed by CUNY are only eligible for membership in TRS and may join at their option. Additional information on choosing a pension plan is available from Jared Herst, PSC Coordinator of Pension and Welfare Benefits, at (212) 354-1252, or jherst@pscmail.org. This chart, which compares the two systems, may assist new members in choosing their pension plan.

CUNY's Pension Options

System	New York City Teachers' Retirement System (TRS)	Optional Retirement Program
Type of Basic Retirement Plan	**Defined benefit plan:** Benefits are based on age, Final Average Salary* (FAS) and years of employment. *Final Average Salary (FAS): Average of your highest five consecutive annual salaries with certain limitations.	**Defined contribution plan:** Benefits are based on the amounts contributed by the employer and employee and earnings of the employee's choice of investments.
Vesting	After ten years of total credited service.	After 366 days of continuous full-time employment. (Immediate if employee has a pre-existing, vested TIAA-CREF Retirement Annuity (RA) or Group Retirement Annuity (GRA) contract.)
Retirement Age	**Age 63:** Immediate, unreduced benefits. **Ages 55 to 62:** Immediate, reduced benefits at 6.5% per year between those ages.	**No age limitation:** A member may choose to retire and begin annuity income after vesting without a reduction in benefits.
NYC Retirement Health Benefits	Full-time CUNY employees with 10 years of credited service, age 55 or older and receiving a pension. Health insurance premiums are deducted from employees' basic pension payouts in retirement.	A member with at least 15 years of pensionable, continuous, full-time CUNY service and who is at least age 62. **Note:** As of 9/1/05, if you are a health-benefits-eligible retiree, you are required to maintain $50,000 in reserve, with TIAA-CREF, in order to pay for retiree health insurance premiums. Additional reserve amounts may be required depending on the health plan you select or to cover future insurance rate increases.

System	New York City Teachers' Retirement System (TRS)	Optional Retirement Program
Retirement Allowances	**For members who join TRS after 3/31/2012:** **Less than 20 years of service:** 1.67% x FAS x years of service. **20 years of service:** 1.75% x FAS x years of service. **More than 20 years of service:** 1.75% x FAS x years of service (for first 20 years) + 2% FAS for each year of total service credit above 20.	Retirement benefits are based on total accumulations, age at retirement, and the income options selected.
Contribution Rates	Employee pays 3% of regular compensation on a federally tax-deferred basis through 3/31/2013. Thereafter, the contribution rate varies for the remainder of service, dependent upon an employee's salary: --$45,000 or less: 3.00% --More than $45,000 to $55,000: 3.50% --More than $55,000 to $75,000: 4.50% --More than $75,000 to $100,000: 5.75% --More than $100,000: 6.00% Employer contributes a lump-sum annually to TRS.	Employee pays 3% of regular compensation on a federally tax-deferred basis through 3/31/2013 Thereafter, the contribution rate varies for the remainder of service, dependent upon an employee's salary: --$45,000 or less: 3.00% --More than $45,000 to $55,000: 3.50% --More than $55,000 to $75,000: 4.50% --More than $75,000 to $100,000: 5.75% --More than $100,000: 6.00% Employer pays 8% of salary for first seven years of employment and 10% thereafter until the remainder of the employee's service.
Tax-Deferred Annuity (TDA)	Voluntary TRS TDA 403(b) is available for members of TRS basic retirement plan.	Voluntary TIAA-CREF TDA 403(b) is available.
	Note that other tax-deferred retirement investment options are also available. For more information, contact your campus HR benefits officer or reach out to Jared Herst at PSC-CUNY.	
Retirement Disability Benefits	**Ordinary Disability benefits:** 10 or more years of service credit required. **Accident Disability Benefits:** No minimum service requirement.	A member who has been certified disabled and retires may receive annuity payments and city-provided health benefits after 10 years of full-time service.
Death Benefit: Beneficiar(ies) of <u>Active</u> Employees in Basic Pension.	Member contribution accumulation (member contributions + interest) + death benefit equal to one year's salary for one year of service, two years' salary for two years of service and three years' salary for three or more. Reductions may be applicable depending on age.	Total accumulations in a member's basic retirement plan.
Loans	Yes, to the maximum allowable by law from a member's contributions to basic retirement plan, TDA, 457(b) and 401(k) plans.	Yes, to the maximum allowable by law from a member's basic retirement plan, TDA, 457(b) and 401(k) plans.

*The preceding is for informational purposes only. It is a preliminary interpretation of 2012 Tier VI legislation & subject to change.

The City University of New York
Information Regarding Pension System Membership

I. Full-Time Instructional Staff (Including Higher Education Officers, Teaching Faculty, Librarians, Registrar Series Employees, Counselors, Executive Compensation Program and Substitute titles):

All full-time Instructional Staff are eligible for membership in either the Optional Retirement Program (ORP), which refers to membership in TIAA-CREF and the Alternate Funding Vehicles after vesting, or the Teachers' Retirement System of the City of New York (TRS). In some cases, an employee who is already a member of the New York City Employees' Retirement System (NYCERS) and who is appointed to a full-time Instructional Staff position may retain membership in NYCERS as a "Transferred Contributor", thereby revoking his/her rights to join any other public pension plan in the future. Regardless of choice, pension membership, with the exception of Substitutes or Visiting Professor titles, is mandatory for all full-time Instructional Staff. ***Substitutes can join the ORP or TRS*** (unless they are Transferred Contributors of another public pension).

New Instructional Staff who are NYCERS members on a leave of absence from a civil service position must make an election to remain in NYCERS until they have relinquished their leave. The employee has thirty (30) days to: 1) elect to remain in NYCERS as a "Transferred Contributor" and must resign the underlying title; 2) transfer to TRS with no need to resign the underlying title; or 3) elect membership in the ORP with no need to resign the underlying title.

1) **Remain a NYCERS member,** you must resign your NYCERS-eligible position and complete a Transferred Contributor Affidavit (download from www.nycers.org). You must notify your Human Resource officer of your resignation in writing then send the affidavit, along with proof of resignation to your Benefits Officer. They will send verification of your resignation along with other documents to NYCERS. **Choosing "Transferred Contributor" status means that you will be renouncing any present or prospective benefit from any other New York City public employee retirement system.**

2) **Join TRS and then transfer your NYCERS membership,** complete a TRS membership application (download from www.trsnyc.org) and submit it to TRS. To transfer your NYCERS membership, complete NYCERS' Transfer Form #321 (download from www.nycers.org) and submit it to your Benefits Officer. **Please be advised that you are not required to resign your NYCERS eligible position if you choose this option.**

3) **Join ORP, if** you choose TIAA-CREF and are transferring from a NYCERS eligible tittle, there is no need to resign your underlying position.

Any member of NYCERS as long as they resign from NYCERS, who is eligible to elect membership in the ORP, may be able to retain rights to a NYCERS retirement benefit, even if normal vesting time frames have not been met, provided contributions to the pension system are not withdrawn.

By law, Instructional Staff participating in the ORP who are reclassified must remain a member of the TIAA-CREF pension system, unless there is a break in service. However, Instructional Staff enrolled in the ORP who transfer from full-time status to part-time status must remain in the ORP.

II. Full-Time Classified Staff:

All full-time Classified Staff are required to join the New York City Employees' Retirement System six months after gaining permanent status .(Those in provisional status may elect to join earlier) .Classified Managerial are also given the opportunity to join the ORP upon appointment to their position pursuant to the rules cited in section I.

My signature below indicates that I have read the information above and have consulted with my College Human Resources Office regarding any questions concerning my pension system options and rights.

Signature	Name (print)	Date	HR Office Verification

The information provided within this document is based upon currently available information and should not be considered the sole source of information regarding pension membership. In all cases, the provisions of governing laws, rules and regulations prevail.

The City University of New York

RETIREMENT PROGRAM ELECTION FORM
For Full-Time Staff / Civil Service Managers

This form is to be used for eligible employees of CUNY who are appointed, promoted, transferred or re-classified to an eligible Full-time Staff / Classified Managerial position. For those electing the Optional Retirement Program (ORP), this election form must be accompanied by proof of online enrollment with TIAA-CREF. **New employees who do not complete the election process within the statutory time frame noted in the attached information sheet are by law forced into membership with TRS or, if Classified Managerial, into NYCERS.**

Section 1: Personal Information

Name:_____ Last four digits of Social Security Number: _____

Home Address:_____

College:_____ Job Title:_____ Pension Member # (if any):_____

Section 2: Election of Retirement Program

Having received written notification of my retirement system options and having satisfied myself as to the desired retirement system available to me by or pursuant to law in connection with my employment by the City University of New York, I hereby make the following election in regard to my participation in the retirement system as specified below: (check one only)

1)_____ **The Optional Retirement Program (ORP) – For Instructional Staff Only (must enroll online).**
I have attached the TIAA-CREF Retirement Annuity Application.
a) *Visiting Professors- Have the option to join TIAA-CREF if they work at least 50% of a full-time schedule and have a pre-existing vested open account with the TIAA/CREF retirement system.*
b) *Substitute Titles –Have the option to join TIAA-CREF.*

2)X **Teachers' Retirement System of The City of New York – For Instructional Staff Only**
a) *Visiting Professors or Substitute Titles–Have the option to join TRS as of January 2004.*
b) *Non-Teaching Adjuncts – Have the option to join TRS as of February 2002.*
c) *If already a member of TRS as a "Transferred Contributor" through a former position in public service, you may elect to remain in TRS.**
d) *Visiting Professors can join TRS, if they have a current account open with TRS.*

3)_____ **The New York City Employees' Retirement System – Classified Managerial Only**
a) *If already a member of the NYCERS as a "Transferred Contributor" through a former position in public service, you may elect to remain in NYCERS.**

4)_____ **The Board of Education Retirement System*** (for current members only);

5)_____ I have been appointed to a **Substitute or Visiting** Professor title and opt not to join the ORP or TRS; therefore, I choose not to be a member of a pension system at this time.

Signature Name (Print) Date HR Office Verification

***Those participating as Transferred Contributors please check here** ☐

CUNY THE GREATEST URBAN UNIVERSITY IN THE WORLD

Commuter Benefit Solutions Edenred

login.commuterbenefits.com

Submit completed form to your college Benefits Officer

TRANSIT BENEFIT PLANS

EMPLOYEE ACTION

☐ NEW (Enroll) ☐ CHANGE PERSONAL INFORMATION (Change Mailing Address, Email, or Phone) ☐ CHANGE DEDUCTION (Change Transit Plan and/or Amount Deducted from Pay each Month) ☐ SUSPEND DEDUCTION (Temporarily Stop Transit Plan Deduction from Pay) ☐ CANCELLATION (Terminate Your Transit Plan Payroll Deduction)

EMPLOYEE IDENTIFICATION (Please fill out ALL fields completely. Please print.)

Employee N Number (Located on your paycheck stub) ☐☐☐☐☐☐☐☐☐ **Date of Birth** (MM/DD/YYYY) ____/____/____

First Name _____ **M.I.**_____ **Last Name** _____

Address _____

Email _____ **Phone** _____

TRANSIT PLAN AUTHORIZATION (Please select ONE, enter your initials and the monthly deduction amount.)

☐ COMMUTER CARD – UNRESTRICTED ($1.25 Monthly Admin Fee through Payroll Deductions)		☐ TRANSIT PASS ($2.05 Monthly Admin Fee through Payroll Deductions)	
Employee Initials	**Monthly Deduction Amount***	**Employee Initials**	**Monthly Deduction Amount***
	$ _____ . _____		$ _____ . _____

*For the Access-A-Ride, Commuter Card-Unrestricted, and Transit Pass plans you may elect any amount up to $800.

SUSPEND TRANSIT PLAN DEDUCTION

Submit at least 2 weeks before you want to suspend your payroll deduction. Remember, administrative fee deductions will continue when applicable. If you are also enrolled in the Park-N-Ride Plan, the parking plan will be suspended for the same period. Please note this will only suspend your payroll deduction. To also suspend your Transit Pass orders, you must do so directly with Edenred at (833) 584-8109 or online at login.commuterbenefits.com.

PAY DATE TO SUSPEND DEDUCTION MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐☐☐ PAY DATE TO RESUME DEDUCTION MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐☐☐

EMPLOYEE CERTIFICATION

I hereby authorize the City University of New York to deposit my payroll deduction as indicated above into my Edenred Commuter Benefit Transit Account.

I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the "National Automated Clearing House Association" guidelines and rules, the City University of New York can only reverse the amount of the incorrect direct deposit.

I understand, according to the Internal Revenue Code, that the average monthly amount of my transportation deductions should not exceed my average monthly cost of public transportation to and from work. If my average monthly cost of public transportation to and from work should change, I will change my deduction plan to accommodate my new circumstance. Furthermore, no reimbursement will be provided for pre-tax transportation fringe deductions. Upon termination, voluntary or otherwise, any funds remaining in my Transit Account will be available for use for a period of 90 days from the effective date of termination. Residual funds remaining in the account beyond the 90 day period will be forfeited.

I understand there is a monthly non-refundable fee to cover administrative costs of the program. The administrative fee will be deducted from my post-tax pay each month according to the following table:

TRANSIT PLAN	MONTHLY FEE	CHARGE METHOD
Commuter Card-Unrestricted	$1.25	Deducted from post-tax pay
Transit Pass	$2.05	Deducted from post-tax pay

I grant authorization for the City University of New York to provide my enrollment information, including mailing address, phone number and e-mail address to Edenred for use exclusively related to the administration of the program. This authorization will remain in effect until I submit a new request for a change or cancellation.

I understand that my Transit Account balance and information will be maintained by Edenred and are accessible online at login.commuterbenefits.com or by calling Edenred Customer Service at (833) 584-8109.

Employee Signature _____ **DATE** MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐☐☐

AGENCY PAYROLL SECTION

Agency Code	Personal information updated (check all that apply): ☐ Mailing Address ☐ Email ☐ Phone ENTRY DATE MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐☐☐		
I certify that the above data was entered in Edenred & PayServ:	Prepared By (Please Print)	Signature	Date

(02/2020)

The Health Care Flexible Spending Account (HCFSA) Program and the Dependent Care Assistance Program (DeCAP) are divisions of the Office of Labor Relations' Flexible Spending Accounts Program.

PLAN YEAR 2022 ENROLLMENT/CHANGE FORM
FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM

nyc.gov/fsa

Please review the FSA Program Brochure on the FSA website, and Pages 3 and 4 of this form before completing.

PROGRAM (CHECK ONE): ❑ HCFSA *or* ❑ DeCAP *or* ❑ HCFSA and DeCAP

❑ **ENROLLMENT PERIOD:** Open Enrollment Period (October 12, 2021 - November 19, 2021) - *Skip Section C*

❑ **MID-YEAR ENROLLMENT/CHANGE:** (January 1, 2022 - November 11, 2022) **- Please complete all appropriate sections, including Section C for mid-year enrollment.**

❑ **NEWLY ELIGIBLE EMPLOYEE:** Hire date: _____ /_____ /_____ Benefit effective date, if later than hire date: _____ /_____ /_____

❑ **CHANGE:** ❑ Name ❑ Address ❑ Agency Transfer ❑ Dependent ❑ Direct Deposit ❑ Annual Contribution

❑ HCFSA ONLY - Continuation of Coverage* to accelerate payroll deductions: Last pay date: _____ /_____ /_____ Last date at work: _____ /_____ /_____

* Continuation of Coverage: Please refer to page 3 for detailed information.

SECTION A — *Employee, Spouse and Dependent Information*

1. EMPLOYEE (PARTICIPANT) INFORMATION *(ALL SECTIONS MUST BE COMPLETED.)*

SOCIAL SECURITY NUMBER	DATE OF BIRTH	FEDERAL MARITAL STATUS
- -	/ /	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Legally Separated

AGENCY NAME (NOT DIVISION): (CUNY - PLEASE SPECIFY NAME OF COLLEGE)

Check here ❑ If you are on a weekly payroll.

LAST NAME	FIRST NAME	M.I.

HOME ADDRESS - NUMBER AND STREET	APT. NO.

CITY	STATE	ZIP CODE

DAYTIME PHONE NUMBER	MOBILE PHONE NUMBER	EMAIL ADDRESS
( ) -	( ) -	

2. SPOUSE INFORMATION *(PLEASE NOTE: DOMESTIC PARTNERS/CIVIL UNIONS ARE NOT ELIGIBLE FOR THE FSA PROGRAM.)*

SOCIAL SECURITY NUMBER	DATE OF BIRTH	EMPLOYMENT STATUS * Must provide proper documentation under DeCAP ** Not eligible under DeCAP *** Need description of occupation on letterhead stationery; or with no letterhead stationery, notarization is required
- -	/ /	❑ Employed ❑ Self-Employed*** ❑ Full-Time Student* ❑ Disabled* ❑ Unemployed**

LAST NAME	FIRST NAME	M.I.

3. DEPENDENT INFORMATION *(LIST ALL YOUR ELIGIBLE DEPENDENTS. CHECK THIS BOX ❑ IF ATTACHING AN ADDITIONAL PAGE.)*

FOR DeCAP: THE DEPENDENT MUST BE CLAIMED ON YOUR INCOME TAX RETURN AND UNDER THE AGE OF 13.

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	RELATIONSHIP TO EMPLOYEE			
					(CHECK ONE)	C	AC	DC
					C = CHILD UNDER AGE 13	C	AC	DC
					AC = CHILD AGE 13 THROUGH AGE 26	C	AC	DC
					DC = DISABLED CHILD	C	AC	DC

SECTION B — *Annual Contribution Amount* (January 1, 2022 - December 31, 2022)*

Health Care Flexible Spending Account	$_____ HCFSA	❑ Initial Annual Contribution: Minimum $260 - Maximum $2,850 ❑ Change Annual Contribution: ❑ Increase

* Your DeCAP and HCFSA annual contribution amount will be prorated over each paycheck. Please note that CUNY and DOE/Q Bank will be prorated over 24 paychecks.

Dependent Care Assistance Program	$_____ DeCAP	❑ Initial Annual Contribution: Minimum $500 - Maximum $5,000 ❑ Change Annual Contribution: ❑ Increase ❑ Decrease or ❑ Terminate (Note: If you are married and filing separate income tax returns, the maximum that you may allocate to DeCAP is $2,500.)

Does your spouse's employer offer a DeCAP that you take part in? ❑ No ❑ Yes If Yes, Dollar Amount $_____

The total combined Plan Year dollar amount for you and your spouse cannot exceed $5,000.

Please Sign Section F on Page 2.

Over ⟶

SECTION C — Mid-Year Qualifying Event Enrollment/Change

Please indicate the Qualifying Event incurred and attach appropriate documentation. All Qualifying Events MUST be submitted with appropriate documentation in order to be processed. This change must be consistent with your Qualifying Event and described on Page 3 of this Enrollment/Change Form. You must return this form within 30 days after the Qualifying Event indicated below.

Qualifying Event (Please Write):	Qualifying Event Date: / /

HCFSA and DeCAP - Qualifying Events and Required Documentation

- Marriage - Marriage certificate
- Birth of a child - Birth certificate
- Death of participant - Death certificate
- Adoption of a child - Adoption agreement and employee's tax return showing eligible dependents
- New employee - Letter from employer/agency
- Termination of employment (self) - Letter from employer/agency
- Approved unpaid leave of absence (during Open Enrollment Period) - Letter from employer/agency

DeCAP Only - Qualifying Events and Required Documentation

- Divorce/legal separation/annulment - Divorce, annulment decree/separation agreement
- Death (spouse or dependent) - Death certificate
- Change from FT to PT employment or vice versa-Letter from employer/agency (self, spouse)
- Approved unpaid leave of absence - Letter from employer/agency (self, spouse)
- Termination of employment - Letter from employer (self, spouse)
- Reduction or increase of hours worked - Letter from employer (self, spouse)
- Ineligibility of dependent - Birth certificate or other appropriate documentation

SECTION D — Direct Deposit Information - (MUST ATTACH VOIDED CHECK)

NOTE: If you participated in FSA in Plan Year 2021 and your Direct Deposit Information on file remains the same, you do not need to complete this section for Plan Year 2022.

***ABA NUMBER:** CHECKING ACCOUNT - THE ABA NUMBER IS THE FIRST NINE (9) NUMBERS PRIOR TO THE ACCOUNT NUMBER AT THE BOTTOM LEFT CORNER OF THE CHECK. SAVINGS ACCOUNT - CONTACT YOUR BANK FOR THE ABA NUMBER, IF NOT KNOWN. ****ACCOUNT NUMBER:** SEE CHECK, PASSBOOK, OR ACCOUNT STATEMENT FOR ACCOUNT NUMBER.

Account Type: (Check only one)	Person(s) Named on Account (Please Print Clearly)	ABA Number* (Must be 9 Digits)	Attach VOIDED Check Here
❑ Checking ❑ Savings	Person 1: _____ Person 2: _____	Account Number** (Please Write)	

SECTION E — Authorizations, Annual Salary Reduction Agreement and Certification of Qualifying Event

Authorization and Annual Salary Reduction Agreement

I have read the printed material explaining the HCFSA and/or DeCAP benefits and my choices under these programs. I have also read the Enrollment/Change Form information on Pages 3 and 4 of this form. I understand that by signing and submitting this Enrollment/Change Form, I am making a binding election as to my benefit coverage for the Plan Year that begins on January 1, 2022. I authorize my Employer to reduce my gross salary as indicated on this form in order to pay for the benefits I have elected. I understand that my payments will be pro-rated over each payroll period.

NOTE: I understand that my HCFSA election cannot be reduced or revoked for any reason except for termination of employment during the Plan Year, or if I should take an unpaid leave of absence. I agree to pay, in full, the amount elected on this form for the Plan Year for HCFSA, by recalculating the payroll deductions upon returning from unpaid leave. My HCFSA and/or DeCAP election can only be changed if I experience a Qualifying Event (Section C). I further understand that each account is separate and that DeCAP funds cannot be used for or transferred to HCFSA or vice-versa. I understand that any amount remaining in these FSAs that is not used during the Plan Year and HCFSA Grace Period, if applicable, will be permanently forfeited by me. I understand that I am only eligible to receive reimbursement on behalf of my eligible dependents listed on this form.

I understand that I will be terminated from participation in the Program if I cease employment with the City of New York or go on an unpaid leave of absence, unless I elect to participate in the Continuation Coverage for HCFSA.

Direct Deposit Authorization

I hereby authorize the Flexible Spending Accounts Program to deposit my HCFSA/DeCAP reimbursement directly into my checking or savings account as requested. I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the "National Automated Clearing House Association" operating guidelines and rules, the Flexible Spending Accounts Program can only reverse the amount of the incorrect direct deposit. I agree that this authorization will remain in effect until I provide to the Flexible Spending Accounts Program a written cancellation to terminate the service. I will notify the Flexible Spending Accounts Program if my bank account numbers listed above should change.

Mid-Year Qualifying Event

This is to certify that I incurred the Qualifying Event indicated in Section C and, therefore, wish to modify my benefits as indicated. I understand that the change(s) in benefits requested must be consistent with the Qualifying Event, and that I must provide approved documentation of all change(s), and that the effective date of the change(s) will be the date the forms are received by the Plan Administrator or the date of my first payroll deduction if I become eligible after the beginning of the Plan Year. The participant has the burden of proof to show that the Qualifying Event is acceptable under the Plan. The Plan Administrator reserves the right to request additional information. The Plan Administrator has, among other duties, the power and duty to interpret the Qualifying Event and to resolve ambiguities, inconsistencies and omissions.

SECTION F — Employee/Participant Signature

SIGNATURE:	DATE: / /

Please submit this form electronically to: *https://nyc-fsa.leapfile.net*
Retain a copy for your records

DO NOT WRITE IN THIS AREA

Payroll				
Program	Initials	Date	PMS DOC#	Other Payroll
HCFSA		/ /		
DeCAP		/ /		

Database	
Initials	Date
	/ /
	/ /

Agency Payroll Code
New York State I.D. Number

The Health Care Flexible Spending Account (HCFSA) Program and the Dependent Care Assistance Program (DeCAP)
are divisions of the Office of Labor Relations' Flexible Spending Accounts Program

PLAN YEAR 2022 ENROLLMENT/CHANGE FORM
FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM

nyc.gov/fsa

By signing the Enrollment/Change Form:

- I authorize my Employer to reduce my gross salary before federal income taxes and Social Security (FICA) taxes are calculated by the total amount of the annual salary reduction (Plan Year 2022 contribution amount) indicated on Page 1.
- I understand that contributions to the FSA Program may reduce my Social Security benefits, since Social Security contributions will be based on my adjusted gross salary.
- I authorize the FSA Program to deposit my HCFSA/DeCAP reimbursement directly into my checking or savings account as requested (See Section D).

Under HCFSA

- I understand that the amount of salary reduction will continue throughout the Plan Year and cannot be reduced or revoked for any reason except for termination of my employment during the Plan Year or if I should take an unpaid leave of absence.
- I understand that I may enroll in the Program or increase my contribution should I become eligible to participate in this Program or acquire new dependents during mid-year. I understand that I must complete all applicable sections of this form and submit it to the FSA Program Administrator within thirty (30) days after a Qualifying Event in order to enroll and/or add dependents. A Qualifying Event can be marriage, adoption or birth of a child, commencement of new employment with the City, or employee's return from approved unpaid leave of absence (taken during the Open Enrollment Period) or termination of participant's employment with the City of New York.
- I understand that I will be reimbursed for eligible expenses up to my total annual contribution amount, less the administrative fee and any claims previously reimbursed, regardless of the current balance in my account.
- I understand that any health care expense defined by the IRS as a non-deductible expense for income tax purposes shall be ineligible for reimbursement. I further understand that although an expense may be deductible for income tax purposes, it may be ineligible for reimbursement under this Program.
- I understand that my personal and claim information will not be released to any other individual unless I complete the Health Insurance Portability and Accountability Act (HIPAA) Protected Health Information (PHI) Authorization Form.
- I understand that I have the right to revoke my HCFSA HIPAA authorization at any time in writing by emailing the Program through the FSA website at nyc.gov/fsa.

HCFSA Continuation of Coverage - Employees Terminating Employment/Unpaid Leave of Absence

If you terminate your employment with the City of New York or go on an unpaid leave of absence during the Plan Year, you cannot submit any claims for services rendered after your termination date, or effective date of your unpaid leave of absence, unless you elect Continuation of Coverage. You may elect to deduct the remaining balance of your goal amount on a pre-tax basis either by lump-sum or pro-rated payroll deductions with the remaining paychecks, as long as the FSA Program Administrator is able to meet the payroll deadlines for the applicable pay dates. Otherwise, you may continue coverage by submitting payment to the FSA program with post-tax dollars. Department of Education employees terminating employment in the summer must notify the FSA Program Administrative Office by the first week in May 2022.

- I understand that I will be terminated from participation in the HCFSA Program, unless I elect HCFSA Program Continuation Coverage. In this case, I agree to fund the balance of my HCFSA goal amount for the current Plan Year with either (a) pre-tax dollars deducted from my last paycheck(s) or accelerated for the remaining paychecks prior to leaving City service; or (b) post-tax dollars for the remainder of the current Plan Year.
- I understand that if I elect HCFSA Program Continuation Coverage and would prefer that the balance of my goal amount for the current Plan Year be deducted from my last paycheck(s) or accelerated for the remaining paychecks on a pre-tax basis, I will notify the FSA Program Administrative Office in writing by emailing the Program through the FSA website at nyc.gov/fsa thirty (30) days prior to the date I cease employment, or as soon as possible in order for the FSA Program Administrator to meet payroll deadlines.
- I understand that if I take an unpaid leave of absence, I must notify the FSA Program Administrative Office to recalculate the deduction amount upon my return from the unpaid leave of absence and the FSA Program Administrative Office may also recalculate the deduction amount if necessary as long as it is within the same calendar year and within the payroll cut-off dates.
- I authorize the FSA Program Administrative Office to recalculate any missed HCFSA payroll deduction amounts, if the FSA Program Administrator identifies such missed deductions.

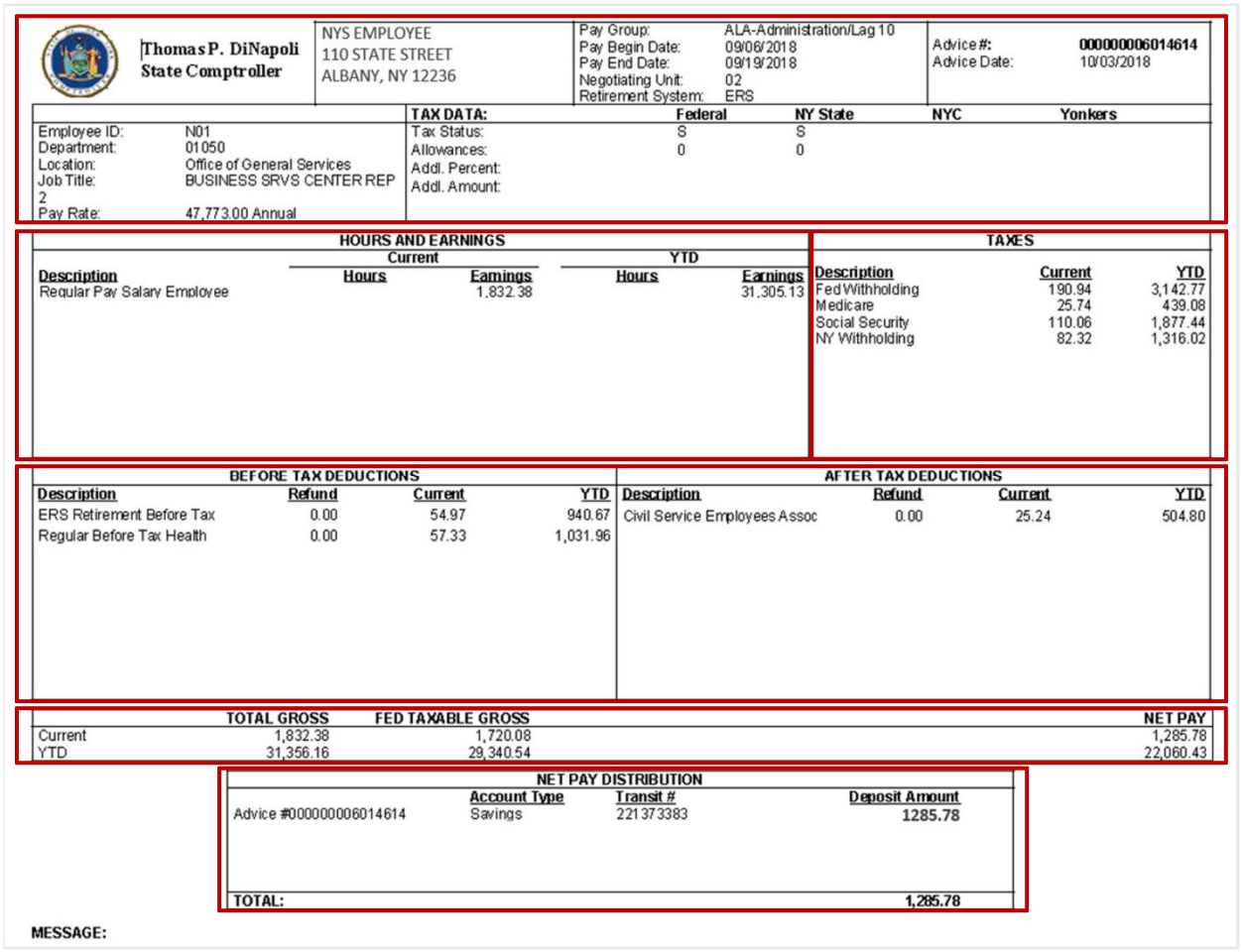
Under DeCAP

- I understand that the amount of salary reduction will continue throughout the Plan Year, unless I incur an approved Qualifying Event. I understand that I must complete all applicable sections of this form and submit it to the Plan Administrator within thirty (30) days after a Qualifying Event in order for any change to be effective.

- I understand that I may enroll in the Program or increase my contribution should I become eligible to participate in this Program or acquire new dependents during mid-year. I understand that I must complete all applicable sections of this form and submit it to the Plan Administrator within thirty (30) days after a Qualifying Event in order to enroll and/or add dependents. A Qualifying Event can be marriage, adoption or birth of a child, commencement of new employment with the City, employee's return from approved unpaid leave of absence (taken during the Open Enrollment Period) or termination of participant's employment with the City of New York.
- I understand that I will be reimbursed up to the total current balance in my account less the administrative fee. Any amounts requested for reimbursement which exceed the current balance in my account will be carried forward to the next month.
- I understand that if I am married and my spouse is not employed, he/she must be either: a) incapable of self-care or b) a full-time student.
- I understand that I may not receive a benefit for eligible employment-related dependent care expenses incurred by me which is in excess of my Earned Income or the Earned Income of my spouse, if I am married.

Under HCFSA and DeCAP

- I understand that if I do not experience accurate payroll deductions, it is my responsibility to notify the FSA Program immediately.
- I understand that the funds in these FSAs can only be paid out to reimburse eligible medical and/or dependent care expenses actually incurred after the start of my participation in the FSA Program and during the Plan Year and HCFSA Grace Period, if applicable.
- I understand that I have the burden of proof to show that each medical and/or dependent care expense is reimbursable under the FSA Program, as well as eligible and reimbursable under all regulations (including the Internal Revenue Code).
- I understand that, under all circumstances, the FSA Program Administrator reserves the right to request additional information.
- I understand that the FSA Program Administrator has, among other powers and duties, the power and duty to interpret the FSA Program and to resolve ambiguities, inconsistencies, and omissions.
- I understand that if I participate in both the HCFSA Program and DeCAP, I cannot transfer funds from one account to the other.
- I understand that there is a maximum administrative fee of $4.00 per month per account.
- **I understand that any amount remaining in these FSAs that is not used during the Plan Year, Claims Run-Out Period and HCFSA Grace Period, if applicable, will be permanently forfeited by me.**



Thomas P. DiNapoli
State Comptroller

NYS EMPLOYEE
110 STATE STREET
ALBANY, NY 12236

Pay Group: ALA-Administration/Lag 10
Pay Begin Date: 09/06/2018
Pay End Date: 09/19/2018
Negotiating Unit: 02
Retirement System: ERS

Advice #: 000000006014614
Advice Date: 10/03/2018

A

		TAX DATA:	Federal	NY State	NYC	Yonkers
Employee ID:	N01	Tax Status:	S	S		
Department:	01050	Allowances:	0	0		
Location:	Office of General Services	Addl. Percent:				
Job Title:	BUSINESS SRVS CENTER REP 2	Addl. Amount:				
Pay Rate:	47,773.00 Annual					

B

HOURS AND EARNINGS

Description	Current Hours	Current Earnings	YTD Hours	YTD Earnings
Regular Pay Salary Employee		1,832.38		31,305.13

C

TAXES

Description	Current	YTD
Fed Withholding	190.94	3,142.77
Medicare	25.74	439.08
Social Security	110.06	1,877.44
NY Withholding	82.32	1,316.02

D

BEFORE TAX DEDUCTIONS

Description	Refund	Current	YTD
ERS Retirement Before Tax	0.00	54.97	940.67
Regular Before Tax Health	0.00	57.33	1,031.96

AFTER TAX DEDUCTIONS

Description	Refund	Current	YTD
Civil Service Employees Assoc	0.00	25.24	504.80

E

	TOTAL GROSS	FED TAXABLE GROSS	NET PAY
Current	1,832.38	1,720.08	1,285.78
YTD	31,356.16	29,340.54	22,060.43

NET PAY DISTRIBUTION

	Account Type	Transit #	Deposit Amount
Advice #000000006014614	Savings	221373383	1285.78
TOTAL:			1,285.78

MESSAGE:

A. GENERAL INFORMATION

- **Heading:** identifies the employee by name and address.
- **Pay Group:** identifies a group of employees with similar attributes whose paychecks are processed together.
- **Pay Begin Date and Pay End Date:** identifies the period for which the employee is being paid.
- **Negotiating Unit:** the code indicating the union that represents the employee.
- **Retirement System:** represents the retirement system that the employee belongs to.
- **Advice Number or Check Number:** a unique number that identifies the document.
- **Advice Date or Check Date:** date of payment.
- **Employee ID:** a unique number used for identifying the employee.
- **Department and Location:** the 5-digit agency or facility code and name.

- **Job Title:** the employee's position.
- **Pay Rate:** for annual salaried employees, an annual amount; for hourly employees, an hourly rate.
- **Tax Data:** a summary of federal, state and local tax status data, as identified by the employee. This section identifies marital status (single or married), number of exemptions (allowances), and additional withholding amounts requested by the employee.

B. HOURS AND EARNINGS

- **Current Earnings:** all types of earnings for the current pay period.
- **Current Hours:** identifies number of units on which certain earnings are based; for example, overtime hours, holiday days, or overtime meals for the current pay period.
- **YTD Earnings:** earnings by type, for the calendar year.
- **YTD Hours:** identifies number of units on which certain earnings are based, for the calendar year.

C. TAXES

- **Taxes:** withholdings for the current pay period and calendar year-to-date for each tax category. This includes federal income tax, Medicare, Social Security, and state and local income taxes.

D. DEDUCTIONS

- **Before Tax Deductions:** deductions which reduce taxable gross salary.
- **After Tax Deductions:** deductions which are included in taxable gross (for example, union dues, union-sponsored insurances and SEFA contributions) for the current pay period and year-to-date.
  NOTE: Benefits may also be listed for which no employee contribution is made, such as non-contributory membership in the Employees Retirement System. In those cases, the benefit will be listed with no amount.
- **Refund:** deduction amounts, by type, refunded for this pay period.
- **Current Deductions:** deduction amounts, by type, for this pay period.
- **YTD Deductions:** deduction amounts, by type, for the calendar year.

E. PAYCHECK TOTALS

- **Current Total Gross:** gross earnings paid this pay period.
- **Current Federal Taxable Gross:** gross earnings paid this pay period and any amounts paid by voucher that are subject to federal income tax.
- **Current Net Pay:** earnings paid for this pay period after all taxes and deductions. This amount equals the amount of the check received or direct deposits made.
- **YTD Total Gross:** gross earnings paid to date for the calendar year.
- **YTD Federal Taxable Gross:** gross earnings paid for the calendar year that are subject to federal income tax.
- **YTD Net Pay:** total earnings paid to date (after all taxes and deductions) for the calendar year.

Source NYS Controller Office