Office of Human Resources Management
University Benefits Office
555 West 57th Street, 11th Floor
New York, NY 10019
Tel: 646-664-3351
Fax: 646-664-3418

Date: October 21, 2016

To: CUNY Doctoral Students

From: University Benefits Office

Subject: **NYSHIP ANNUAL OPEN ENROLLMENT PERIOD**

Annual Open Enrollment

The Fall 2016 **Annual Open Enrollment Period** for eligible participants in the New York State Health Insurance Program (NYSHIP) is November 1 through November 30, 2016. **If you are not making changes to your current plan, then no action will be required on your part.**

During the Annual Open Enrollment Period you will be able to:

- Enroll in coverage or add eligible dependents to coverage without the 30-day waiting period usually applied to late enrollments *(Enrollment/addition of dependent(s) will be effective on the date the enrollment form is received by the contact person indicated below)*
- Change from family to individual coverage, without providing proof of other health coverage, even if you are in pre-tax status (*Change to individual coverage will be effective as of the first full pay-period of 2017*)
- Cancel coverage, without providing proof of other health coverage, even if you are in pre-tax status (*Cancellation of coverage will be effective as of the first full pay-period of 2017*)
- Change from pre-tax to post-tax status or from post-tax to pre-tax status (*Change of tax status will be effective as of the first full pay-period of 2017*)

Please note that employees enrolled in pre-tax status have deductions taken prior to their paycheck being taxed but are limited in the changes they can make during the year. Employees enrolled in post-tax status are able to change from family to individual coverage or cancel their coverage at any time.

Enrollment or Changes during Annual Open Enrollment Period

If you are participating in the Annual Open Enrollment Period, you must complete and submit the Health Benefits Enrollment Form (PS-404) attached to this letter. If you are adding an eligible dependent, you must provide acceptable documentation* as proof of eligibility for your dependents.

*****Refer to the dependent eligibility requirements for enrollment located here: NYSHIP Eligibility Requirements for a listing of acceptable documentation.

If you are enrolled in a Ph.D. Program at the CUNY Graduate Center, the form must be returned to Scott Voorhees at the Graduate Center, room 7301.05.

If you are an Engineering Ph.D. Student at City College, the form must be returned to the Kim Ferguson at City College, Shepard Hall, room 50.

If you are enrolled in a Ph.D. Program at the CUNY School of Public Health, the form must be returned to Carmen Vason at the CUNY School of Public Health, room 723.

If you are enrolling in benefits or adding dependents to coverage, you should expect to receive your benefit cards in the mail (at your home address on file) within 3 to 4 weeks from the date your enrollment is processed.

If you are not making changes to your current plan, then no action will be required on your part. Your insurance will continue without a lapse in coverage, assuming you continue to meet the eligibility requirements. The next opportunity you will have to make changes to your coverage as outlined above will be if you experience a Qualifying Event or during the 2017 Annual Open Enrollment.

Eligibility
As a reminder, you are eligible to participate in NYSHIP if you are a matriculated Doctoral Student at the CUNY Graduate Center or in the Engineering Ph.D. Program at City College and simultaneously employed in one of the following Professional Staff Congress (PSC) represented titles: Graduate Assistant A, B, C, D, Adjunct Instructor, Adjunct Lecturer, Adjunct College Laboratory Technician or Non- Teaching Adjunct I, II. Additional eligibility requirements are noted here: NYSHIP Eligibility Requirements

Eligible Dependent
You may enroll your eligible dependent(s) if their relationship to you is one of the following:

- Spouse
- Domestic Partner
- Dependent Children (under 26 years of age) – The term "children" includes natural children, adopted children, dependent step children.
- Disabled Dependents (26 years of age or older)

For additional information on the New York State Health Insurance Program you may visit our NYSHIP website. Please contact the NYSHIP Coordinator at your college if you have any questions:

If you are a Ph.D. student at the CUNY Graduate Center, please contact Scott Voorhees at healthinsuranceinfo@gc.cuny.edu or by telephone at 212-817-7406.

If you are an Engineering Ph.D. Student at City College, please contact Kim Ferguson at kferguson@ccny.cuny.edu or by telephone at 212-650-7963.

If you are enrolled in a Ph.D. Program at the CUNY School of Public Health, please contact Carmen Vason at Carmen.Vason@sph.cuny.edu or by telephone at 212-817-7718.

Enclosure

cc: Esdras Tulier
Andrea Yenco
William McGowan
Human Resources Directors
Benefit Officers

State of New York
Department of Civil Service
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION
NYS HEALTH INSURANCE TRANSACTION FORM

PS-404 (10/06)

INSTRUCTIONS: READ AND COMPLETE BOTH SIDES/PAGES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.

EMPLOYEE INFORMATION *(All employees must complete)*

1. Last Name First Name MI	**2.** Social Security Number	**3.** Sex ☐ Male ☐ Female	
4. Street Address City State Zip			
5. Date of Birth	**6.** Telephone Numbers Home ( ) Work ( )	**7.** Work location and address	
8. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Marital Status Date		
9. Covered under Medicare? Self ☐Yes ☐ No Spouse/Domestic Partner ☐Yes ☐ No			

10. ENTER REQUEST(S) BELOW

A. ☐ Request Enrollment- **Individual**	Medical *(10)* *(Select Empire Plan or HMO)* ☐Empire Plan ☐ HMO* Code ☐ Name ☐	☐ Dental *(11)*	☐ Vision *(14)*
B. ☐ Request Enrollment- **Family** (Complete G)	Medical *(10)* *(Select Empire Plan or HMO)* ☐Empire Plan ☐ HMO* Code ☐ Name ☐	☐ Dental *(11)*	☐ Vision *(14)*
C. ☐ Elect Pre-Tax Status for Premium deduction?	☐ Yes ☐ No If yes, initial here to indicate that you have read the Pre-Tax Contribution memorandum. ____		
D. ☐ Decline Coverage	☐Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* *(Process WAV/BEN transaction)*		
E. ☐ Voluntarily Cancel Coverage	☐Medical *(10)* Qualifying Event:	☐ Dental *(11)*	☐ Vision *(14)*

F. ☐ Change Coverage ☐Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* **Date of Event:** ____

☐ **Change to FAMILY** *(Complete G)*
- ☐ Marriage
- ☐ Domestic Partner
- ☐ First dependent child acquired
- ☐ Dependent returned to full-time student status
- ☐ Request coverage for dependents not previously covered
- ☐ Newborn
- ☐ Previous coverage terminated *(Complete Section 11)*
- ☐ Other ____

☐ **Change to INDIVIDUAL**
- ☐ I voluntarily cancel coverage for my dependents
- ☐ I voluntarily cancel coverage for my domestic partner
- ☐ Only dependent died
- ☐ Only dependent married
- ☐ Only dependent graduated
- ☐ Divorce
- ☐ Only dependent disqualified by age
- ☐ Termination of domestic partnership *(Attach Completed PS-425.4)*
- ☐ Other ____

G. **DEPENDENT INFORMATION** *(use additional sheets if necessary)*

Check One: A (Add), D (Delete) or C (Change)
Check all that apply: M (Medical), D (Dental), and V (Vision)
Date of Event ____

	Last Name First Name MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security Number
☐A ☐D ☐C ☐M ☐D ☐V						
☐A ☐D ☐C ☐M ☐D ☐V						
☐A ☐D ☐C ☐M ☐D ☐V						
☐A ☐D ☐C ☐M ☐D ☐V						
☐A ☐D ☐C ☐M ☐D ☐V						

**** A completed HMO form must be attached.***

NYS Department of Civil Service
Albany, NY 12239

Health Insurance Transaction Form
PS-404 (10/06) Page 2

10. *Continued*. **ENTER REQUEST(S) BELOW**

H. ☐ Change Medical Benefit Plan — Change to: ☐ Empire Plan ☐ HMO * Code ☐ HMO Name _____
* A completed HMO form must be attached.

I. Change Pre-Tax Status — Change to: ☐ Pre-Tax ☐ Post-Tax — Processed only by the Employee Benefits Division during the Pre-Tax Contribution Selection Period (November)

11. PREVIOUS COVERAGE INFORMATION

If you were previously covered under NYSHIP or another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.

Previous ID Number

Date Coverage Terminated _____

Enrollee's Name Under Which Previously Covered — Last — First — Middle Initial

12. LEAVE WITHOUT PAY AND RETIREMENT STATUS

LEAVE WITHOUT PAY

☐ I wish to continue coverage while I am on authorized leave. I understand that I will be billed for this coverage. ☐ Medical ☐ Dental ☐ Vision

☐ I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll. ☐ Medical ☐ Dental ☐ Vision

RETIREMENT

☐ I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage.

☐ I understand the requirements for continuing medical insurance coverage as a retiree and wish to defer my coverage. *(A completed PS-406.2 must be attached.)*

13. REQUEST FOR EMPIRE PLAN CARD ONLY

For Health Maintenance Organization (HMO) cards, contact your HMO.

☐ DUPLICATE CARD
(Previously issued card remains valid.)
☐ REPLACEMENT CARD
(Previously issued card(s), lost or stolen, become invalid.)

FOR
☐ ENROLLEE
☐ ENROLLEE AND ALL DEPENDENTS
☐ INDIVIDUAL DEPENDENT
Name _____

Personal Privacy Protection Law Notification

This information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 457-9375. For information related to the Health Insurance Program, **contact your Agency Health Benefits Administrator**. If, after calling your Agency Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

AUTHORIZATION

I have read the Pre-Tax Contribution Program memorandum and have made my selection on Page 1 of this document, if applicable. I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving State service (vest, retirement, etc.). **I certify that the information I have supplied is true and correct.** I understand that my failure to provide required proof(s) within 28 days (30 days for newborns) may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims. I hereby ***authorize deduction from my salary or retirement allowance*** of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

→ Employee's Signature **(Required)** _____ Signature Date **(Required)** _____

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	Date of 1st Eligibility (PE only)	Percentage Working	Agency Code	Neg. Unit	Ret. System

Retirement Tier	Registration #	Sick Leave Information # Hours	Sick Leave Information Hourly Rate of Pay	Date Entered on NYBEAS	Effective Date

HBA Signature: **Date:**