Applicant MUST check one:

☐ **EMPLOYEE**
☐ **RETIREE**

Health Benefits Application

City of New York
Health Benefits Program

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
- ☐ Cancel Benefits (Check one)
  - ☐ Waive Benefits
  - ☐ Buy-Out Waiver Program (Employees only) (Complete Sections D, E, F & I only)
- ☐ Other _____

B. Transfer of Health Plan and/or Optional Benefits Based on:
- ☐ Transfer Period
- ☐ Permanent Move Into/Out of Health Plan Area

mo dy yr
Eff. Date: / /
- ☐ Retiree Once-in-A-Lifetime
- ☐ Other _____

C. Change Of:
- ☐ Spouse/Domestic Partner

mo dy yr
☐ Add ☐ Drop / /

Dependent Child(ren) mo dy yr
☐ Add ☐ Drop / /

- ☐ Change of Name - Former Name: _____

D. EMPLOYEE/RETIREE INFORMATION

Last Name	First Name	M.I.	Social Security Number	Tel.No: Home: ( ) Cell: ( )
			_ _	

Home Address - Number and Street	Apt. No.	Date of Birth	Sex
		/ /	☐ Male ☐ Female

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

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership	Date of Event / /	Agency in which employed or retired from	Union or Welfare Fund

Name of Current City Health Plan	Medicare Claim No.	☐ If Medicare Part A - Effective Date / / ☐ If Medicare Part B - Effective Date / /	**Attach copy of card**

Retirement System (Retirees Only)	Yrs. Credited Service	City Start Date	Retirement Date	Pension Number (Retirees Only)
		/ /	/ /	

E. SPOUSE/DOMESTIC PARTNER INFORMATION

Last Name	First Name	M.I.	Social Security Number	Date of Birth
			-- --	/ /

Is your spouse/domestic partner: ☐employed ☐retired ☐not employed
☐ City Agency Name: _____ ☐ Non-City related

Is spouse/partner to be covered by employee/retiree's health plan?
(Double City coverage is not permitted) ☐ Yes ☐ No

Does spouse/partner have Non-City group health plan? ☐Yes ☐No	Medicare Claim No.:	☐ If Medicare Part A - Effective Date / / ☐ If Medicare Part B - Effective Date / /	**Attach copy of card**

F. FAMILY INFORMATION (Attach a second form if necessary; dependents may not be covered under two NYC Health Plans.)

(List all eligible dependents to be covered by your health plan)

		Birth Date MO DY YR	Social Security Number	Sex M/F	Check if Applicable: Full-Time Student	Permanently Disabled	Drop Coverage
Spouse/Domestic Partner Last Name	First	/ /	- -				
Dependent Last Name	First	/ /	- -				
Dependent Last Name	First	/ /	- -				
Dependent Last Name	First	/ /	- -				

G. HEALTH PLAN REQUESTED

HEALTH PLAN NAME IN FULL (Please Print Clearly): _____

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. TO PARTICIPATE IN THE HEALTH BENEFITS PROGRAM - PLEASE SIGN & DATE BELOW (Participant must sign either Section H or I)

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 _____ Date _____

I. TO PARTICIPATE IN THE HEALTH BENEFITS BUY-OUT WAIVER PROGRAM - SIGN & DATE BELOW (Participant must sign either Section H or I)

I wish to partipcate 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 **not** Eligible.)

Employee Signature _____ 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 Form and I attest that the employee meets the qualifications for this Program.

✍ Certifying Signature _____ Date _____ Telephone Number _____

Agency Code	Title Code No	Status	Appointment Date/Ret. Date	Pay Period	Effective Date of Coverage
		☐ FT ☐ Civil Service ☐ PT ☐ Provisional	MO DY YR	☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Semi-Monthly	MO DY YR

Health Plans Available to Employees, Non-Medicare Retirees and their Dependents

Aetna HMO
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 Health Plan (HHC Employees and Non-Medicare Retirees only)
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 Golden Medicare 10
Avmed Medicare Plan
Cigna HealthCare for Seniors* (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 Medicare Plan*
Humana Gold Plus (certain counties in Florida)*
SecureHorizons by UnitedHealthCare*

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.

Instructions for Completing a Health Benefits Application for Retirees

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

Section A: If you are a NEW retiree, you should only select from the following: Retirement, Disability Retirement, Accident Disability Retirement, Deferred 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 Transfer Period if the change you are requesting is being made during a Transfer Period (such as Adding Optional Benefits or Changing Plans). 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 C: Check Spouse 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 a 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, you must attach a copy of the marriage certificate or submit domestic partner documentation if adding a domestic partner. Check Dependent (Children) (Add/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.

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 whether or not 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 dependents to be covered. You must indicate yes/no if a dependent is a full-time student. If a dependent is permanently disabled, and on Medicare, you must attach a photocopy of his/her Medicare card.

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 is the only section in which you are to sign the form. Remember to date your form.

Section I: (Retirees not eligible) Buy-Out Wavier Program.

Section J: If you are a NEW retiree (even if you are waiving City coverage), your payroll/personnel office must complete this section.

Retirees: Return this application to:

City of New York
Health Benefits Program
40 Rector Street – 3rd Floor
New York, New York 10006

HUNTER COLLEGE
DESIGNATION OF BENEFICIARY
(Non-Instructional Staff)

Please Print Name _____ Soc. Sec. No. _____

Title _____ Agency The City University of New York

ACCIDENTAL DEATH BENEFIT

(Not applicable for Section 220 employees except Laborers)

I. In accordance with the provisions of Personnel Orders No. 26/71, 28/71, and 74/76, the accidental death benefit of $25,000 provided for therein is to be paid to the beneficiaries designated below in the following order:

	Name of Beneficiary	Relationship	Address % of Benefits
1)			
2)			
3)			

If none of the above-designated beneficiaries shall survive me, payment shall be made to my estate.

UNUSED ANNUAL LEAVE AND ACCRUED OVERTIME BENEFIT

II. In accordance with the provisions of Mayor's Executive Order No. 34, dated March 26, 1971, the lump-sum cash payment for accrued and annual leave and accrued compensatory time provided for therein is to be paid to the following beneficiary or beneficiaries or to my estate as indicated below in the following manner (fill in below if you desire to name a beneficiary other than your estate).

	Name of Beneficiary	Relationship	Address % of Benefits
1)			
2)			
3)			

It is my understanding that by not designating a beneficiary this benefit will be paid to my estate.

ALL PREVIOUS DESIGNATED BENEFICIARIES ARE HEREBY CANCELLED AND IT IS DIRECTED THAT PAYMENT BE MADE UPON MY DEATH AS SPECIFIED ABOVE.

Signature of employee (do not print) Address of employee

Signed at (City, State) Date signed

Signature of witness (do not print) Address of witness

Signed at (City, State) Date signed

NOTE: It is your responsibility to submit a new designation of beneficiary whenever changing personal circumstances make a change in beneficiary necessary

OFSR 459

* * * * * * * THIS FORM MUST BE NOTARIZED * * * * * * *

EMPLOYEE Health Plan Rates as of July 1, 2015

These rates are in effect as of the first full payroll period in July 2015

(All rates are subject to change)

		Weekly		Bi-Weekly		Semi-Monthly	
		Individual	Family	Individual	Family	Individual	Family
Aetna EPO	Basic Plan	$36.79	$188.29	$73.57	$376.57	$80.14	$410.20
Optional Rider	Prescription Drugs	53.77	136.21	107.55	272.43	117.15	296.75
	TOTAL	**$90.56**	**$324.50**	**$181.12**	**$649.00**	**$197.29**	**$706.95**
CIGNA HealthCare	Basic Plan	$139.39	$379.29	$278.79	$758.58	$303.68	$826.31
Optional Rider	Prescription Drugs	51.79	155.04	103.57	310.09	112.82	337.78
	TOTAL	**$191.18**	**$534.33**	**$382.36**	**$1,068.66**	**$416.50**	**$1,164.08**
DC37 Med-Team (DC 37 members only)	Basic Plan	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
(No Rider Available)	**TOTAL**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Empire EPO	Basic Plan	$128.75	$328.88	$257.49	$657.77	$280.49	$716.50
Optional Rider	Prescription Drugs	36.06	88.40	72.12	176.79	78.56	192.58
	TOTAL	**$164.81**	**$417.28**	**$329.61**	**$834.56**	**$359.04**	**$909.07**
Empire HMO	Basic Plan	$49.45	$149.33	$98.90	$298.66	$107.73	$325.33
Optional Rider	Prescription Drugs	36.06	88.40	72.12	176.79	78.56	192.58
	TOTAL	**$85.51**	**$237.72**	**$171.02**	**$475.45**	**$186.29**	**$517.90**
GHI-CBP/Empire BlueCross BlueShield							
	Basic Plan	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Optional Rider	Prescription Drugs	27.54	49.34	55.08	98.69	60.00	107.50
	Enhanced Major Medical Coverage	1.55	3.93	3.10	7.86	3.38	8.56
	TOTAL	**$29.09**	**$53.27**	**$58.18**	**$106.55**	**$63.38**	**$116.06**
GHI HMO	Basic Plan	$24.73	$76.87	$49.45	$153.73	$53.87	$167.46
Optional Rider	Prescription Drugs	44.96	114.64	89.93	229.27	97.96	249.75
	TOTAL	**$69.69**	**$191.50**	**$139.38**	**$383.01**	**$151.83**	**$417.21**
HIP Prime HMO	Basic Plan	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Optional Rider	Prescription Drugs	33.98	83.24	67.95	166.49	74.02	181.35
Durable Medicate Equipment & Private Duty Nursing		1.32	3.23	2.63	6.45	2.87	7.03
	TOTAL	**$35.29**	**$86.47**	**$70.59**	**$172.94**	**$76.89**	**$188.38**
HIP Prime POS	Basic Plan	$151.37	$370.92	$302.75	$741.83	$329.78	$808.07
Optional Rider	Prescription Drugs	121.44	295.85	242.88	591.69	264.57	644.52
	TOTAL	**$272.82**	**$666.76**	**$545.63**	**$1,333.53**	**$594.35**	**$1,452.59**
Metroplus (HHC Employees Only)	Basic Plan	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Optional Rider	Prescription Drugs	35.15	80.74	70.30	161.47	76.58	175.89
	TOTAL	**$35.15**	**$80.74**	**$70.30**	**$161.47**	**$76.58**	**$175.89**
Vytra	Basic Plan	$17.52	$71.64	$35.05	$143.28	$38.18	$156.08
Optional Rider	Prescription Drugs	39.02	101.47	78.03	202.94	85.00	221.06
	TOTAL	**$56.54**	**$173.11**	**$113.08**	**$346.22**	**$123.18**	**$377.14**

NYCERS USE ONLY **F103**

Application for Membership
For NYCERS-Eligible Employees

This application is for City employees who wish to apply for NYCERS membership. You are to also nominate a beneficiary for a death benefit payable if you die while in City Service. Please read the Instructions Page before completing this form. You must submit this ENTIRE form, even if you intentionally leave some of the sections blank. Should you have any questions regarding this application, please contact our Call Center at 347-643-3000.

Social Security Number	Date of Birth [MM/DD/YYYY]	Daytime Phone Number	Email Address
	/ /	( )	

First Name	M.I.	Last Name	Sex (M or F)

In Care of (if applicable)

Address	Apt. Number

City	State	Zip Code

Agency	Pass Number (Transit Only)

Your job title as it appears on payroll	Date of Appointment [MM/DD/YYYY]	Civil Service Appointment Date
	/ /	/ /

Classification (Check one) ☐ Competitive ☐ Exempt ☐ Labor ☐ Non-Competitive ☐ Provisional

Beneficiary Selection: A designated beneficiary is the person who is on file at NYCERS to receive a survivor benefit upon the death of a member in active service.

I understand that should I nominate more than one beneficiary, my death benefit will be paid in accordance with the percentages I have indicated on this form (combined percentages should total 100%). If no percentage is indicated, the death benefit will be shared equally. I understand that should I survive the beneficiary(ies), the benefit will then be payable to my estate.

The beneficiary(ies) whom I wish to nominate to receive my death benefit is:

Primary Beneficiary

First Name	M.I.	Last Name

Full Social Security Number	Date of Birth [MM/DD/YYYY]	Relationship
	/ /	

Address	Apt. Number

City	State	Zip Code

☐ If this beneficiary is a minor, check here and complete the guardian information on **Form 137**

Percentage ____ %

Sign this form and have it notarized, Page 3

NYCERS USE ONLY **F103**

NYCERS — NYC Employees' Retirement System

Member's Last Name	Social Security Number

Designation of Beneficiary(ies) continues below

Primary Beneficiary

First Name	M.I.	Last Name

Full Social Security Number	Date of Birth [MM/DD/YYYY]	Relationship
	/ /	

Address	Apt. Number

City	State	Zip Code

☐ If this beneficiary is a minor, check here and complete the guardian information on **Form 137**

Percentage ____ %

Primary Beneficiary

First Name	M.I.	Last Name

Full Social Security Number	Date of Birth [MM/DD/YYYY]	Relationship
	/ /	

Address	Apt. Number

City	State	Zip Code

☐ If this beneficiary is a minor, check here and complete the guardian information on **Form 137**

Percentage ____ %

Primary Beneficiary

First Name	M.I.	Last Name

Full Social Security Number	Date of Birth [MM/DD/YYYY]	Relationship
	/ /	

Address	Apt. Number

City	State	Zip Code

☐ If this beneficiary is a minor, check here and complete the guardian information on **Form 137**

Percentage ____ %

☐ I am nominating my Estate as my beneficiary for my regular death benefit. I understand that in order for this selection to be valid I may not write in any other beneficiary's name on this form, and I have, in fact, left all other designation of beneficiary sections on this form blank.

Should your death be the result of an on-the-job accident, an accidental death benefit is payable according to a priority order specified in law.

NYCERS USE ONLY **F103**

Member's Last Name | Social Security Number

If this form was reviewed by your agency have the representative sign here:

Family Information

Mother's Maiden Name

Record of Previous Service

If you are or were a member of this or any other retirement system in the City or State of New York, fill in the name of that system, period of membership and membership number, if known.

Name of System | Membership Number

From [MM/DD/YYYY] / /

To [MM/DD/YYYY] / /

Purchase of Previous Service

You may be eligible to purchase retirement credit for previous service rendered anywhere in New York State. Contact NYCERS for further information and forms.

Military Service

If you are an honorably discharged veteran of the armed forces of the United States of America, fill in your dates of service. (You may be eligible to purchase this service)

From [MM/DD/YYYY] / /

To [MM/DD/YYYY] / /

Once a membership application has been PROCESSED for payroll deductions, membership may not be withdrawn as long as you remain in City service.

I hereby elect to participate in NYCERS membership and contribute for the right to retire.

Signature of Member | **Date**

This form must be acknowledged before a Notary Public or Commissioner of Deeds

State of _____ County of _____ On this ____ day of _____ 2 0____, personally appeared

before me the above named, _____, to me known, and known to me to be the individual described in and who executed the foregoing instrument, and he or she acknowledged to me that he or she executed the same, and that the statements contained therein are true.

If you have an official seal, affix it

Signature of Notary Public or Commissioner of Deeds _____

Official Title _____

Expiration Date of Commission _____

Sign this form and have it notarized, THIS PAGE

NYCERS
NYC Employees' Retirement System

INSTRUCTIONS FOR COMPLETING THIS FORM

1. In addition to this application, you must submit a copy of your birth certificate.

2. At the top of each page of this form, print your name.

3. State the full name of your beneficiary(ies) (first name, middle initial, if any, and last name), relationship to you, Social Security #, date of birth and complete address, (number, street, apartment number, if any, city, state and zip code). Do not use the words "same as above" or use ditto marks, inasmuch as it renders the form invalid.

4. You MAY name a trustee under any designated beneficiary.

5. You must return all pages of this form even if you have intentionally left portions blank. You do not have to return the Instruction Page if you received or downloaded it as a stand alone page.

6. Be sure to sign this form, in the space provided for Signature, in the presence of a Notary Public or Commissioner of Deeds.

7. Page 3 of this form must be acknowledged before a Notary Public or Commissioner of Deeds.

8. Complete this form in ink or type. Except for signature, please print all items.

9. **Do Not** make erasures, use white-out or cross-out any typed or printed information on this form, inasmuch as it renders it invalid.

10. If you need assistance completing this form, please contact NYCERS at 347-643-3000.

Client Services 340 Jay Street Brooklyn, NY 11201
(347) 643-3000 **www.nycers.org**
Mailing Address 335 Adams Street, Suite 2300 Brooklyn, NY 11201-3724

WageWorks®

THE CITY UNIVERSITY OF NEW YORK COMMUTER BENEFITS PROGRAM
TRANSITBENEFIT PLANS

Submit completed form to: Your College TransitBenefit Coordinator www.cuny.edu/transitbenefit www.getwageworks.com/nyc

EMPLOYEE ACTION

☐ **NEW** (Enroll)
☐ **CHANGE PERSONAL INFORMATION** (Change Mailing address, Email or Telephone)
☐ **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 (All fields in this section are required and must be filled out completely. Please Print.)

Social Security / ERN	DOB MM__/DAY__		
Name (First/Middle/Last)			
Address Line 1			
Address Line 2**			
City/State/Zip			
Email Address		**Telephone**	

* Located on your pay statement or check stub. ** Apt.#, Fl.# or Box# if applicable.

TRANSIT PLAN AUTHORIZATION (Please select One of the following plans by writing your initials in the column next to the Transit Plan of your choice. Please enter the total amount, including dollars and cents, you want deducted from your pay each month.)

ACCESS-A-RIDE ($3.05 Monthly Admin Fee through Payroll Deductions)		COMMUTER CARD - Unrestricted ($1.77 Monthly Admin Fee through Payroll Deductions)		TRANSIT PASS ($3.05 Monthly Admin Fee through Payroll Deductions)	
Employee Initials	**Monthly Deduction Amount***	Employee Initials	**Monthly Deduction Amount***	Employee Initials	**Monthly Deduction Amount***
	$		**$**		**$**

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

SUSPEND TRANSIT PLAN DEDUCTION

Submit at least 2 weeks before you want to suspend your deduction. Remember, administrative deductions will continue when applicable. If you are also enrolled in the Commuter Benefits Parking 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 Wageworks at **www.wageworks.com** or 1-877-924-3967.

PAY DATE TO SUSPEND DEDUCTION MONTH DAY YEAR

PAY DATE TO RESUME DEDUCTION MONTH DAY YEAR

EMPLOYEE CERTIFICATION

I hereby authorizeTthe City University of New York to deposit my payroll deduction as indicated above into my Wageworks Commuter Benefits 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" operating 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 cancellation, 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 cancellation. Residual funds remaining in the account beyond the 90 day period will be forfeited.

I understand there is a monthly fee to cover administrative costs of the program. Said fee will deducted from my post-tax pay each month. The administrative charge is non-refundable. The administrative fees and charges are as follows:

TRANSIT PLAN	FEE	CHARGE METHOD
Access-A-Ride	$3.05	Deducted from post-tax pay
Commuter Card-Unrestricted	$1.77	Deducted from post-tax pay.
Transit Pass	$3.05	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 Wageworks for uses exclusively related to the administration of the program.

I understand that this authorization will remain in effect until I submit a new request for a change or cancellation.

I understand that my Commuter Benefits transit account balance and information will be maintained by Wageworks and are accessible online at **www.wageworks.com** or by calling Wageworks Customer Service at 1-877-WageWorks (1-877-924-3967).

Employee Signature _____ **DATE** MONTH DAY YEAR

AGENCY PAYROLL SECTION

Payroll #

Personal information updated in PayServ / PMS (check all that apply):
☐ **Mailing Address** ☐ **Email Address** ☐ **Phone Number**

PAYSERV / **PMS ENTRY DATE** MONTH DAY YEAR

I certify that the above data was entered in PMS via EForms:

Prepared By (Please Print)	**Signature**	**Date**