**The City University of New York**

# RETIREMENT PROGRAM ELECTION FORM
## for Full-Time Instructional 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 instructional staff / Civil Service Managerial position and must be filed within 30 days of written notification of eligibility (for new employees, filing must occur within 30 days of appointment). For those electing the Optional Retirement Program (ORP), this election form must be accompanied by a TIAA/CREF Application to complete the election process. **Those staff failing to complete the election process within the statutory time frame noted above, are forced into membership with the NYCTRS by law (Civil Service Managers into the NYCERS).**

**Section 1: Personal Information**

**Name:**_____ **Social Security Number:**_____

**Address:**_____

**College:**_____ **Job Title:**_____ **Pension Mem. No. (if any):**_____

**Section 2: Election of Retirement Program**

Having received written notification of my retirement program options and having satisfied myself as to the desired retirement program 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 program as specified below: (check one only)

1)____ **The Optional Retirement Program (ORP).** I have attached the required TIAA/CREF Regular Annuity Application materials;

2)____ **The New York City Teachers' Retirement System*** (Instructional Staff members only, unless already a member of the NYCTRS through a former position in public service);

3)____ **The New York City Employees' Retirement System*** (Classified Managers only, unless already a member of NYCERS through a former position in public service);

4)____ **The Board of Ed Retirement System*** (for current members only);

5)____ I have been appointed to a **Substitute** position, and **opt not to join the ORP;** therefore I choose not to be a member of a pension system at this time.

_____

Employee Signature/Date Verification by Personnel/Date

*Those participating as Transferred Contributors, please check here. ___

The City University of New York

# Information Regarding Pension System Membership

## I. Full-Time Instructional Staff (Including Exec. Comp, REM & Substitute titles):

All full-time instuctional staff are eligible for membership in either the Optional Retirement Program (ORP), which refers to membership in TIAA/CREF and the Alternate Funding Vehicles, or the New York City Teachers' Retirement System (TRS). In some cases, an employee who is already a member of the New York City Employees' Retirement System (ERS) and who is appointed to a full-time instructional staff position may retain membership in ERS 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, is mandatory for all full-time instructional staff. Substitutes can join the ORP only (unless they are Transferred Contributors of another public pension).

New instructional staff who are ERS members on a leave of absence from a civil service position must remain in ERS until they have relinquished their leave, generally upon attainment of 13.3b status in the Instructional staff position. Once this status is attained, the employee has sixty (60) days to 1) elect to remain in ERS, 2) transfer to TRS, or 3) elect membership in the ORP.

Any member of TRS or ERS who is eligible to elect membership in the ORP may be able to retain rights to a TRS or ERS retirement benefit even if normal vesting time frames have not been met, provided contributions to the system are not withdrawn. Please consult with your college personnel office for details.

## II. Full-Time Civil Service Managers:

All full-time classified service personnel are required to join the New York City Employees' Retirement System after six months from gaining permanent status (those in provisional status may elect to join earlier). Civil Service Managers are also given the opportunity to join the Optional Retirement Program upon appointment to their position, pursuant to the rules cited in "I." above.

**My signature below indicates that I have read the information above and have consulted with my college personnel office regarding any questions I may have had concerning my pension program options and rights.**

Name Signature/Date Personnel Office Verficiation

*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.*

(please attach to CUNY "RETIREMENT PROGRAM ELECTION FORM")

**Fringe Benefit Forms Checklist**

The following forms **must** be returned **to** the Benefits Office (East Building - Room 1504)

**within 30 days** of your Appointment.

Mandatory Benefit Forms

- Death Benefit Beneficiary Designation Card
- Health Benefits Application
- PSC-CUNY Welfare Fund Data Sheet
- Retirement Election Form
- Retirement Application (**Optional for Appointments of Visiting Professors and Substitute Instructional Staff Titles**).
  - **TIAA-CREF** Enrollment Application

    **Or**
  - **New York Teacher's Retirement System (TRS)** Tier VI

    Enrollment Application and Designation of QPP Beneficiary Form.

NOTE:

**Required documents for Health and Welfare Fund Enrollments are:**

Spouse:

- Married one year or less - Government Issued Marriage Certificate
- Married more than one year - Government Issued Marriage Certificate and supporting documents

Domestic Partner:

- Partnership of one year or less - Domestic Partnership Certificate of Registration
- Partnership of more than one year - Domestic Partnership Certificate of Registration and supporting documents

Biological Child:

- Government Issued Birth Certificate

Step Child:

- Must be spouse's child and have supporting documents

Domestic Partner's Child:

- Must be registered domestic partner's child and have supporting documents

## Death Benefit Beneficiary Designation Card

| | | |
|---|---|---|
| Name of Employee<br>(Last) (First) Middle Initial | | |
| Social Security Number | Male ❑<br>Female ❑ | Date of Birth<br>Mo. Day Yr.<br>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<br>Mo. Day Yr. | Signature of Employee | |

**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.

**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**

# 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** |

# Enrollment Form
## PSC-CUNY Welfare Fund

61 Broadway, 15th Floor
New York, NY 10006
Phone (212) 354-5230
Fax (212) 354-5363

[PSC-CUNY WF Office Use Only]
Data _____
Rx _____
ASO _____
Dental _____

☐ Stipend ☐ Waived/Buy-out

***A copy of your NYC Health Beneftis Application and Welfare Fund Domestic Partner Form (if applicable) must be attached.***

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

**Enrollee**

**NY State ID#** N _____

**Last Name** _____ **First Name** _____

**Social Security Number** - - **Job Title** _____

**Home Address** _____

**City** _____ **State** _____ **Zip Code** _____

**Primary Contact #** ( ) _____ **Primary Email** _____

**Date of Birth** / / **Sex** _____ **Marital Status** _____ **Domestic Partner** ☐

**CUNY Campus**

_____

**Health Insurance** Basic ☐ Rider ☐

_____

**Welfare Fund Dental Option**

Guardian ☐

DeltaCare USA ***(Attach DeltaCare Form)*** ☐

**Effective Date of Hire** / /

Earliest CUNY Hire Date / /

Previous College (if applicable) _____

*I hereby certify that all information I have provided on this Enrollment Form is true and accurate.*

**Member Signature** _____ **Date** / /

**[College HR Office Use Only]** ☐ **Check here if this enrollee is classified managerial**

The individual named herein is eligible for coverage effective / /

_____ _____ / /
Signature Position Date

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

_____ _____
Status Authorization

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** |
|---|---|---|
| | | |