2017 Open Enrollment/Change Form

Active SSSA/TSO/Special Inspectors Employees with TWU Local 100 Benefits

HR-BEN-372B

Section 1 - Information and Instructions

The purpose of this form is to enroll in or change health insurance, **effective January 1, 2017.**

Please email a signed copy of the form to bscservice@mtabsc.org or fax to 212-852-8700. If you have any questions, please contact the Business Service Center (BSC) at 646-376-0123.

Section 2 - Employee Information

Print Name	Last	First	M.I.	Suffix	BSC ID / Pass #

Phone (H)	Phone (W)	Email

If your address on your pay stub is incorrect, contact the Business Service Center OR log onto www.mymta.info and change your address online OR complete HR-HRIS-012 Employee Data Change Form. An incorrect address will delay receipt of your new health insurance cards.

Section 3 – Coverage Election – Effective January 1, 2017

Medical ☐ Individual ☐ Family

Check **One**

☐ **AETNA CPOS II BASIC OPTION**

☐ **AETNA CPOS II HIGH OPTION (includes GHI Preferred Dental)**
(Bi-weekly pre-tax required contribution of $13.17 for Individual Coverage and $26.34 for Family Coverage)

☐ **AETNA SELECT OPTION** (Live/work in the New York Service area)

☐ **OPT-OUT PROGRAM (for Medical/Hospital/Prescription Drugs)**

I agree to the Terms and Conditions of the Opt-Out Program on the back of this form. ***Alternate medical information must be provided below.***

Name of Policyholder: _____ Relationship: _____

Policy #: _____ SS# of Policyholder: _____

Name of Insurance Carrier _____ Date of Birth of Policyholder: _____

Employer of Policyholder: _____

Dental ☐ Individual ☐ Family

Check **one** of the following dental plans **ONLY** if you did not enroll in the **High Option**, which includes dental coverage.

☐ **PLAN A-** American Dental Centers ☐ METLIFE PPO ☐ HEALTHPLEX/DENTCARE

☐ **PLAN B-** ProBenefits Administrators (Also known as the Dental Shop ☐ METLIFE FEE SCHEDULE

Section 4 – Dependent Information

If you are found to be covering an ineligible dependent, coverage will be terminated retroactive to the date of the ineligibility and NYC Transit will pursue financial restitution for claims and/or premiums for the ineligible dependent.

1. Please fill in all information for new dependents you wish to enroll and submit required documentation (see Section 6).
2. Please fill in all information for any dependents you wish to delete.
3. Please contact the Business Service Center for the Domestic Partnership Package if you wish to enroll a domestic partner.

NOTE: Your domestic partner will not be enrolled in health coverage unless an application is submitted and approved by the Benefits Department.

Check One - Indicate (A) Add or (D) Delete				Check One - Relationship			Gender		Date of Birth		
A	D	Name	SSN	Spouse	Domestic Partner	Child	F	M	Mo	Day	Year

Section 5 - Authorization

My signature and date on this form certifies and warrants that all dependent eligibility information is true, correct, and current. I also certify that dependent children from age 19 to 26 that I have enrolled in coverage are eligible for coverage.

Employee Signature	Date

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Section 6 – Dependent Required Documentation

1. For a Spouse

A copy of Marriage Certificate, Social Security card, and, if your date of marriage is more than one year old:

- **Your most recent Tax Return**—Federal or State (including Puerto Rico Returns)
  - Your most recent tax return showing "Married Filing Jointly" or "Married Filing Separately". Your spouse's name must appear on the tax form on the line provided after the "married filing separately" status (or vice versa).
  - Only submit page 1 of the tax return. This should include the 1040 form, eFile Confirmation page, Tax Preparer's Summary, or Federal Return Recap.
  - Eliminate all financial information.

OR

- **Proof of Joint Ownership**

  Both the enrollee's and spouse's name must be listed on the documentation of joint ownership and be dated within the past 90 days.

  Examples include a copy of:
  - Homeowners/Renters Insurance Policy
  - Credit Card Statement
  - Loan Obligation
  - Bank Account Statement
  - Pension/life insurance/will designating spouse as beneficiary
  - Mortgage Statement
  - Property Tax Document
  - Rental/Lease Agreement
  - Utility/phone/internet/cable bills

If you are not able to provide the required documentation, please complete the Employee or Retiree Affidavit, have it notarized and return it with your Enrollment form.

2. For Children

For a Natural-Born Child, a copy of:

- Birth Certificate showing employee's name
- Social Security card

For a Stepchild, or Legally Adopted Child, a copy of:

- Birth Certificate
- Social Security card
- Legal documentation concerning adoption

3. Dependent Children Coverage between ages 19 and 26

- To enroll a dependent child from age 19 to 26 in your medical, hospital, and prescription drug coverage, add the child's name on this form, submit required documentation, and affirm by signing this form that your child is eligible for coverage.
- Those who enroll in the High Option are not required to submit student verification from age 19 to 21 to cover dependent children in dental coverage.

Section 7 – The Opt-Out Program Terms and Conditions

Incentive for Opt-Out

You may opt out of medical coverage and receive a lump sum incentive payment. Opting out of medical coverage means that you elect not to participate in medical, hospital, and prescription drug coverage. You will however retain coverage in dental and vision plans. To be eligible, you must document that you will be covered by another medical plan sponsored by:

- a spouse or domestic partner's employer
- another employer
- armed forces

Lump Sum Incentive Payment

Payment of the lump sum incentive will be made at the end of the Opt-Out year in the following amount:

- **$550** for an employee who receives medical coverage through spouse/domestic partner who is also employed by NYC Transit or another MTA agency
- **$550** if you opt-out of *individual* medical coverage
- **$1,100** if you opt-out of *family* medical coverage

If you participate in the Opt-Out Program and either re-enroll or retire during that same year, you will not be eligible to receive any part of the incentive payment.

Terms of Agreement

I understand that this election will be effective from January 1 through December 31, 2017, unless I am no longer allowed by law or as a result of a qualifying event or such other events as the Authority determines will permit a change or revocation of an election.

I understand that the lump sum payment will be subject to all applicable Federal, State and Local taxes. I also understand that these monies will not be considered income for pension purposes and will not be included in any calculation therein.

This agreement is subject to the terms of the employer's plan, as amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws and revokes any prior election and compensation agreement relating to such plan. The health benefits waiver will be administered as permissible under IRS section 125.