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

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

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

Enrollment Form

State
(to be completed by Delta)

DELTA DENTAL®

☑ **New enrollment**

Please return to:
PSC-CUNY Welfare Fund
61 Broadway - 15th Floor
New York, NY 10036
Tel: (212) 354-5230 Fax: (212) 354-5363

☑ **Delta Care USA**

Member Social Security Number	Last Name	First Name	MI	Date of Birth	Gender
					☐ Male ☐ Female

Address *(Is this a change of address?* ☐ *Yes* ☐ *No)* Street City State Zip Code

Group Number
2502

Group Name
PSC - CUNY Welfare Fund

DeltaCare USA Primary Care Dentist *(required for DeltaCare USA enrollees)*

DeltaCare USA Primary Dental Office ID No. *(required for DeltaCare USA enrollees)*

Do you or your dependents have other dental coverage?
☐ Yes ☐ No *If yes, please complete the following:*

Carrier Name and Address: _____

Member Signature _____

Group Number: _____

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse			M F		
Children			M F		
			M F		
			M F		
			M F		
			M F		

Effective Date::

Sublocation::

E/C-S0804

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 Mo. Day Yr.	Signature of Employee	

Return to:
PSC-CUNY Welfare Fund
61 Broadway, 15th Floor
New York, NY 10006

APPLICATION FOR WELFARE FUND BENEFITS FOR DOMESTIC PARTNERS / SAME SEX SPOUSES

Member's Name Last: _____ First: _____ M.I.:__

SSN: _____ Sex: M ☐ F ☐ DOB: ____/_____/19___

Street: _____ Apt: _____ Tel# _____

City: _____ State: _____ Zip: _____

Member's College: _____ Status: Active ☐ Retired ☐

NYC Health Insurance Coverage: _____ Date of Eligibility: ___/____/___

DESIGNATED BENEFICIARY (DOMESTIC PARTNER / SAME SEX SPOUSE):

Last: _____ First: _____ M.I.:__

SSN: _____ Sex: M ☐ F ☐ DOB: ____/_____/19___

Street: _____ Apt: _____ Tel# _____

City: _____ State: _____ Zip: _____

DEPENDENTS

Dependent Children (If unmarried between ages of 19 and 23 or 25 (depending on the Health Insurance you are in) and a full-time student, please indicate college and expected date of graduation). If not your natural child, indicate in each case whether adopted or stepchild and date.

Name	College	Date of Grad.	Status
			☐ Natural ☐ Adopted ☐ Stepchild Date: __/__/__
			☐ Natural ☐ Adopted ☐ Stepchild Date: __/__/__

IMPORTANT NOTES:

1) TAX CONSEQUENCES OF HEALTH BENEFITS FOR DOMESTIC PARTNERS / SAME SEX SPOUSES

You should be aware that, under IRS rulings, if your domestic partner / same sex spouse is not a 'dependent', within the meaning of the Internal Revenue Code, the amount paid by an employer attributable to coverage of a domestic partner / same sex spouse is treated as part of the participant's gross income for Federal tax purposes. Consequently, unless you have indicated and provided proof to the Health Benefits Program (e.g. a copy of a recent tax return) that your domestic partner / same sex spouse is your dependent; the value of this benefit must be included as income in your Federal tax return for the applicable year. State and local tax treatment of the amount in question will vary among jurisdictions. You should consult the applicable laws and/or a tax professional to ascertain how the amount should be treated in your case.

This is to certify that I wish to designate the above named Domestic Partner / Same Sex Spouse as a beneficiary of the PSC-CUNY Welfare Fund Program. I understand that the value of theses befits will be a taxable income to me unless the designated beneficiary qualifies as my dependent under the Internal Revenue Code. The designation will remain in force until revoked by me.

_____

Member's Signature Date

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;~~ Step 2: online enrollment: www.tiaa-cref.org/cuny. Email HR enrollment confirmation from TIAA CREF.

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);
If already a member of TRS, please provide membership #:_____

3) ☐ **The New York City Employees' Retirement System*** (Classified Managers only, unless already a member of NYCERS through a former position in public service);
If already a member of NYCERS, please provide ID #: _____

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. ☐

pnselec.wpd, 8/98

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")

Proof of date of birth required: passport, birth certificate

TRS ENROLLMENT APPLICATION

TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

Please read the instructions before completing this form.
(NOTE: Please print in black or blue ink, and initial any changes that you make on this form.)

PART A: All information must be provided.

First Name | MI | Last Name

Social Security Number ☐☐☐–☐☐–☐☐☐☐

Permanent Home Address | Apt. No.

Primary Phone Number (Check one: ☐ Home ☐ Work ☐ Mobile) (☐☐☐) ☐☐☐–☐☐☐☐

City | State | Zip Code

Alternate Phone Number (Check one: ☐ Home ☐ Work ☐ Mobile) (☐☐☐) ☐☐☐–☐☐☐☐

Date of Birth (M/D/Y) ☐☐/☐☐/☐☐☐☐

Email Address

Gender
☐ Male ☐ Female

TRS Membership Number (if available)

Please keep your personal information with TRS up to date. We will update our records based on the information you provide above, so *do not enter a temporary address*; instead, TRS suggests that you consult the U.S. Postal Service about having your mail forwarded on a temporary basis. To register any changes to your permanent address (and/or phone number), please access our website or file a "Member's Change of Address Form" (code DM13) with TRS.

PART B: Please complete the following information about your employment.

Employer: ☐ Department of Education ☐ Charter School ☐ City University of New York

School Name | Department of Education File Number (if applicable)

School Address | Payroll Title

City | State | Zip Code

Appointment Date (M/D/Y) ☐☐/☐☐/☐☐☐☐

Annual Salary (Rounded to the nearest dollar) $

Have you previously been a member of TRS? If "Yes," write your previous TRS membership number below:

CONTINUED ON PAGE 4

CONTINUED FROM PAGE 3

PART C: If you are now a member or have been a member of any other New York City or New York State public retirement system, or of the Optional Retirement Program, please complete this section.

Note: If you have never been a member of any other New York City or New York State public retirement system, or of the Optional Retirement Program, please do not complete Part C; instead complete Part D below.

Name of your current retirement system (not TRS):

Membership number in the current retirement system (not TRS):

Name of any other previous retirement system:

Membership number in the previous retirement system:

Membership dates in your former retirement system (M/D/Y):

From: ☐☐/☐☐/☐☐☐☐ To: ☐☐/☐☐/☐☐☐☐

Did you retire from your former retirement system? ☐ Yes ☐ No

If "No," do not complete the remainder of Part C. Please proceed to Part D.
If "Yes," please complete the remainder of Part C.

What was your effective retirement date? (M/D/Y): ☐☐/☐☐/☐☐☐☐

Have you suspended your retirement allowance? ☐ Yes ☐ No

If "No," you cannot enroll in TRS at this time.
If "Yes," on what date was your retirement allowance suspended? (M/D/Y): ☐☐/☐☐/☐☐☐☐

I certify that I have read the Enrolling in TRS *brochure, including the information about membership in other retirement systems. I acknowledge my rights as they relate to my previous membership and to my tier status. I understand the conditions of enrolling in TRS, and that TRS must verify my membership eligibility.*

As a retired member of the _____ Retirement System, I have suspended my retirement allowance so that I may enroll in TRS.

I hereby elect to join TRS and make the required pension contributions toward a potential retirement allowance in the future. I understand that I will be enrolled in TRS under the provisions of the tier in effect as of my TRS membership date. I am filing a "Designation of QPP Beneficiary Form" (code EN6), or online equivalent, and documentation of my date of birth in accordance with the instructions in the Enrolling in TRS *brochure. I hereby certify that the information I have provided above is accurate to the best of my knowledge.*

APPLICANT'S SIGNATURE _____ DATE (M/D/Y) _____

PART D: If you are not a retiree of an eligible retirement system, please read the following statement and sign and date below.

I certify that I am not a retiree of an eligible retirement system and that, to the best of my knowledge, I am eligible to enroll in TRS; however, I understand that TRS must verify my membership eligibility. I have read the Enrolling in TRS *brochure, including the information about membership in other retirement systems. I hereby elect to join TRS and make the required pension contributions toward a potential retirement allowance in the future. I understand that I will be enrolled in TRS under the provisions of the tier in effect as of my TRS membership date. I am filing a "Designation of QPP Beneficiary Form" (code EN6), or online equivalent, and documentation of my date of birth in accordance with the instructions in the* Enrolling in TRS *brochure. I hereby certify that the information I have provided above is accurate to the best of my knowledge.*

APPLICANT'S SIGNATURE _____ DATE (M/D/Y) _____

DESIGNATION OF QPP BENEFICIARY FORM

FOR IN-SERVICE MEMBERS UNDER THE QUALIFIED PENSION PLAN

TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

Please read the instructions on pages 3 and 4 before completing this form.
(NOTE: Please print in black or blue ink, and initial any changes that you make on this form.)

PART A: All information must be provided.

First Name | MI | Last Name

Social Security Number (last 4 digits only) X X X – X X – ☐☐☐☐

Permanent Home Address | Apt. No.

TRS Membership Number

City | State | Zip Code

Primary Phone Number (Check one ☐ Home ☐ Work ☐ Mobile)
(☐☐☐) ☐☐☐ – ☐☐☐☐

Alternate Phone Number (Check one ☐ Home ☐ Work ☐ Mobile)
(☐☐☐) ☐☐☐ – ☐☐☐☐

If you are providing new information above, please indicate the effective date (M/D/Y): ☐☐ / ☐☐ / ☐☐☐☐

PART B: Please provide all requested information for each beneficiary and cross out any unused sections below. Please also indicate the total number of beneficiaries listed for this request. ➡ ☐

1.	Beneficiary Name: Street: City, State, Zip:	Primary ☐ Percent (if applicable) _____%	*Check One:* Male ☐ Female ☐	Date of Birth: (mm/dd/yyyy) Relationship: Beneficiary Soc. Sec. No.:
2.	Beneficiary Name: Street: City, State, Zip:	*Check One:* Primary ☐ Contingent ☐ Percent (if applicable) _____%	*Check One:* Male ☐ Female ☐	Date of Birth: (mm/dd/yyyy) Relationship: Beneficiary Soc. Sec. No.:
3.	Beneficiary Name: Street: City, State, Zip:	*Check One:* Primary ☐ Contingent ☐ Percent (if applicable) _____%	*Check One:* Male ☐ Female ☐	Date of Birth: (mm/dd/yyyy) Relationship: Beneficiary Soc Sec No.:
4.	Beneficiary Name: Street: City, State, Zip:	*Check One:* Primary ☐ Contingent ☐ Percent (if applicable) _____%	*Check One:* Male ☐ Female ☐	Date of Birth: (mm/dd/yyyy) Relationship: Beneficiary Soc. Sec. No.:

CONTINUED ON PAGE 2

CONTINUED FROM PAGE 1

Part B: Beneficiary Information *(Continued)*

5.	Beneficiary Name:	*Check One:* ☐ Primary ☐ Contingent	*Check One:* ☐ Male ☐ Female	Date of Birth: (mm/dd/yyyy)
	Street:			Relationship:
	City, State, Zip:	Percent (if applicable) _____%		Beneficiary Soc. Sec. No.:
6.	Beneficiary Name:	*Check One:* ☐ Primary ☐ Contingent	*Check One:* ☐ Male ☐ Female	Date of Birth: (mm/dd/yyyy)
	Street:			Relationship:
	City, State, Zip:	Percent (if applicable) _____%		Beneficiary Soc. Sec. No.:

☐ If you want to designate more than six beneficiaries, check this box and attach a completed "Additional QPP Beneficiary Form" (code EN7).

This form must be signed and notarized in order to be valid.

PART C: Please read the following and sign and date below.

I, the undersigned, revoking all former designations made by me pursuant to my death benefit coverage under the Qualified Pension Plan (QPP), hereby direct TRS, in the event of my death, to pay the QPP death benefit allowable as a lump-sum payment(s) to the beneficiary(ies) named in Part B. Should I survive all named beneficiaries, any death benefit payable shall be paid to my estate.

I certify that I have read the instructions and information on this form and that the information I have provided above is accurate to the best of my knowledge. I have also completed the beneficiary designation checklist below.

BENEFICIARY DESIGNATION CHECKLIST

☐ Is your designation form **signed, dated,** and **notarized**?

☐ Did you indicate the total number of beneficiaries listed for this request in the appropriate box on page 1?

☐ Did you designate at least one primary beneficiary?

☐ Did you initial any changes?

☐ Do all the percentages (if any) you indicated for primary beneficiaries total 100%? Do all percentages (if any) you indicated for contingent beneficiaries, total 100%?

MEMBER'S SIGNATURE _____ DATE (M/D/Y): _____

PART D: To be completed by a Notary (Attestation made outside the U.S. must be executed before an American Consul.)

State of _____)

) s.s.:

County of _____)

On the _____ day of _____, _____, before me personally appeared the person known to me to be _____, the individual who executed the foregoing instrument and acknowledged to me that (s)he executed the same.

Signature: _____

Official Title: _____

Expiration Date of Commission: _____

CONTINUED ON PAGE 3

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 #*	D.O.B 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 per month where the first $245 will be deducted pre-tax and any amount over $245 will be deducted post-tax.

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**
PMS ENTRY DATE MONTH DAY YEAR

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

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

New York State
Deferred Compensation Plan

A Plan for Your Future

ENROLLMENT APPLICATION

DC-4009-0413

New York State
Deferred Compensation Plan
A Plan for Your Future

Welcome to the New York State Deferred Compensation Plan (Plan). The Plan is voluntary, long-term retirement savings program designed for your retirement needs. The amount you contribute to the Plan is deducted from your salary and any investment returns grow on a tax deferred basis.

Contributions to the Plan: The minimum contribution to the Plan is 1% of your gross pay, but must also be at least $10 per pay period. The maximum contribution you may make in 2013 is $17,500. If you are age 50 or over, or will become 50 years old prior to the end of the current calendar year, you are eligible to contribute a maximum of $23,000. If you are within four years of the date that you are eligible to retire without a reduction in pension benefits, you may be eligible to make additional contributions. See your Account Executive or call the HELPLINE (1-800-422-8463) to speak with a representative for more information.

Pre-Tax Deferrals: The amount you contribute to the Plan can be deducted from your salary on a pre-tax basis for federal and New York state income tax purposes and, thereby reducing your taxable income for the calendar year. The investment returns also grow on a tax-deferred basis and income taxes are paid only when money is withdrawn from the Plan.

Roth Contributions: These deductions are made from your pay on an after-tax basis. Contributions grow tax deferred, but when a distribution is qualified, it is not subject to federal or New York State income taxes.

Processing Time Frame: Enrollments are processed upon receipt; however, because of administrative processing, up to two payroll periods may elapse before deferrals begin. Also federal law states that deferrals may not begin before the beginning of the next calendar month, unless you make your election prior to your first day of service. You may change or cancel your deferral amount at any time, but these changes may also be subject to these timing limits.

Next Steps: Please read the bullets below to understand the basics of the Plan and then complete your application.

All information requested in this application must be completed to assure timely processing.

I understand that:

- Withdrawals from the Plan may be taken only upon separation from employment, absence due to qualified military service, death, an unforeseeable financial emergency, attainment of age 70 ½, from an account that has been in inactive status for two years and has a balance of $5,000 (inclusive of any outstanding loan balance but exclusive of assets in a rollover account), or as a loan;

- There is an administrative fee deducted from my Plan Account on a semi-annual basis as outlined in the Plan's Investment Options Guide;

- Participation in the Plan is not intended to replace a regular savings program necessary to cover day-to-day unanticipated financial expenses. The law regulating the Plan limits withdrawals for "Unforeseeable Financial Emergencies" to those that are related to events such as natural disaster, a sudden and unexpected illness or accident, or other similar extraordinary and unforeseeable events beyond my control, involving myself, or my dependents or designated beneficiaries. Should I need an unforeseeable emergency withdrawal, the request must be made in writing and detail the circumstances supporting the financial emergency. If my request is denied, I may appeal to the Review Committee.

- I may enroll in the Plan for the purpose of transferring assets from another deferred compensation plan, a 403(b), 401(k), 401(a), Keogh plan, a traditional IRA or a conduit IRA without becoming an active participant.

- As long as I have provided an accurate email address and have not opted for a paper statement, I will receive an email notification that my quarterly statement, Quarterly Newsletter, and investment performance report are available on the Web site.

- If my employer has opted to allow Roth contributions, contributions to the Roth account may not be reclassified to pre-tax deferrals. The investment allocation for Roth contributions will be the same as for any pre-tax deferrals. Distributions of Roth contributions must meet the withdrawal requirements listed in the first bullet.

Information relating to the Plan or a copy of the Plan document may be obtained by calling the HELPLINE at 1-800-422-8463 or visiting the Plan's Web site at www.nysdcp.com.

New York State
Deferred Compensation Plan
A Plan for Your Future

Account Executive #
Internal Use Only

HELPLINE: 1-800-422-8463
WWW.NYSDCP.COM

ENROLLMENT APPLICATION

PERSONAL DATA

❑ Male
❑ Female

Name (Please Print) _____ Social Security Number _____

Home Address _____ Date of Birth _____

City _____ State _____ Zip _____ Home Telephone Number _____

Employer _____ Work Telephone Number _____

Email Address **(Required – Please see Paperless Statement section for additional detail)** _____ Local Plan ID Number or State Agency Code* _____

New York State Employee ID Number* _____

**If you are unaware of this number, please contact your Payroll Center or the HELPLINE as your enrollment cannot be completed without it.*

BENEFICIARY ELECTION

Please fill in the name, relationship, date of birth, and Social Security Number of each of your primary and contingent beneficiaries. Then indicate the percentage payable to each beneficiary. A person **may not** be listed as both a primary and contingent beneficiary

- Primary Beneficiary (ies) (***must be in whole percentages and total 100%)*** A primary beneficiary is the person or persons who are your first choice to receive your Plan benefits in the event of your death.
- Contingent Beneficiary (ies) (***must be in whole percentages and total 100%)*** A contingent beneficiary is the person or persons who would receive your Plan benefits if all of your primary beneficiary (ies) predeceases you.

Primary Beneficiary (ies) *(must be in whole percentages and total 100%)*

Beneficiary Name	Relationship	Date of Birth	Social Security Number	Percent
				_____%
				_____%
				_____%

Total = 100%

Contingent Beneficiary(ies) *(must be in whole percentages and total 100%)*

Beneficiary Name	Relationship	Date of Birth	Social Security Number	Percent
				_____%
				_____%

Total = 100%

DEFERRAL INFORMATION

Your deferral cannot be less than 1% of your gross salary or less than $10 per pay period. The maximum you may defer in 2013 is $17,500. There are special provisions that may allow you to defer more than $17,500 if you are age 50 or over or will become 50 years old in 2013, or if you are within four years of any age at which you may retire and immediately receive unreduced retirement benefits. If you have questions, please call the HELPLINE at 1-800-422-8463 or visit **www.nysdcp.com** for further information.

Please note that you do not have to select both types of deferrals. If you do select both, the total cannot exceed 100%. If your employer is a local town, village, or school, please check with your payroll department or the HELPLINE to determine whether to insert a dollar amount or a percent. If you are paid through the State Comptroller, please enter a percent.

Pre-Tax Deferral: _____% *(Whole percentages only) per pay period*

Roth Contributions: _____% *(Whole percentages only) per pay period*

DEFERRAL ALLOCATION

Write the percentage you wish to allocate to each investment option. You may allocate your salary deferrals among any of the investment options listed below. The allocation of your contributions may be in any whole percentage and must total 100%.

Tier I - The following investment options are professionally managed asset allocation funds based on your expected retirement date. (Note: Tiers are not related to the Retirement System)

VRU#

_____% (4505) TRP Retirement Date 2010
_____% (4506) TRP Retirement Date 2015
_____% (4507) TRP Retirement Date 2020
_____% (4508) TRP Retirement Date 2025
_____% (4509) TRP Retirement Date 2030

VRU#

_____% (4510) TRP Retirement Date 2035
_____% (4511) TRP Retirement Date 2040
_____% (4512) TRP Retirement Date 2045
_____% (4513) TRP Retirement Date 2050
_____% (4514) TRP Retirement Date 2055

Tier II - The following core investment options permit participants to create their own asset allocation.

Stable Income Fund

_____% (2756) Stable Income Fund

Bond Funds

_____% (4521) Federated Total Return Gov't Fund
_____% (8261) Vanguard Total Bond Market Index

Balanced Funds

_____% (7298) PAX World Balanced
_____% (8957) Vanguard Wellington

Large Cap Funds

_____% (6451) Davis NY Venture Fund A
_____% (4515) Eaton Vance Large Cap Value
_____% (3672) Fidelity OTC Portfolio
_____% (3679) Hartford Capital Appreciation
_____% (4523) Principal Large Cap Growth
_____% (8466) Vanguard Institutional Index
_____% (7739) T. Rowe Price Equity Income
_____% (2765) Vanguard Primecap

Mid Cap Funds

_____% (2570) Perkins Mid Cap Value
_____% (3224) Vanguard Capital Opportunity
_____% (8259) Vanguard Mid Cap Index

Small Cap Funds

_____% (2696) Columbia Acorn USA
_____% (2785) Federated Clover Small Value Fund
_____% (5175) Vanguard Small Cap Index
_____% (4524) Wells Fargo Advantage Small Cap Fund

International Funds

_____% (5025) International Equity Fund – Active Portfolio
_____% (5030) International Equity Fund – Index Portfolio

Emerging Markets

_____% (2766) MSIF Emerging Markets Portfolio

100 % (MUST TOTAL 100%)

Some mutual funds may impose a short- term trade fee. Please read the underlying prospectuses carefully

PAPERLESS STATEMENT OPT OUT

❑ By checking this box, I elect to receive my quarterly statement, newsletter, and Investment Performance Report by regular mail. I understand that by not checking this box, I elect to receive a quarterly e-mail notification, to the email address provided under the Personal Data section, when this quarterly information is posted on the Plan's Web site.

AUTHORIZATION

I agree to the terms of the New York State Deferred Compensation Plan. I authorize my employer to deduct the amount or percentage set forth herein each pay period for the purposes of contributing it to my Plan account. I further authorize my employer to deduct any deferral changes I request through the Plan in the future. This agreement will continue until further notice by me. Deferrals made by other than New York State residents may be subject to their state of residence's income tax in the year deferred. Please read your state income tax instructions carefully.

_____ _____
Participant Signature Date

Return to: New York State Deferred Compensation Plan
Administrative Service Agency
P.O. Box 182797
Columbus, OH 43218-2797

Overnight Address: New York State Deferred Compensation Plan
Administrative Service Agency, DSPF-F2
3400 Southpark Place, Suite A
Grove City, OH 43123-4856

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

PLAN YEAR 2014 ENROLLMENT/CHANGE FORM
FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM

40 Rector Street, 3rd Floor, New York, NY 10006-1705 (212) 306-7760 TTY: (212) 306-7629 nyc.gov/fsa

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

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

ENROLLMENT PERIOD: ❑ Open Enrollment Period (Sept. 9, 2013 - Oct. 18, 2013) - ***Skip Section C***

MID-YEAR ENROLLMENT/CHANGE : ❑ (Oct. 19, 2013 - Nov. 15, 2014) **Check all applicable boxes. 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

❑ DeCAP ONLY- Increase, Decrease or Terminate Contribution ❑ HCFSA ONLY - Increase Contribution

❑ HCFSA ONLY - If you terminate your employment with the City of New York during the Plan Year and would like to elect Continuation 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, as long as the FSA Program Administrator is able to meet the payroll deadlines for the applicable pay dates. Department of Education employees terminating employment in the summer must notify the FSA Program Administrative Office by the second week in May. Last pay date: _____/_____/_____ Last date at work: _____/_____/_____

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 AND HHC EMPLOYEES PLEASE SPECIFY NAME OF COLLEGE OR HOSPITAL)

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

WORK PHONE NUMBER	HOME PHONE NUMBER	MOBILE PHONE NUMBER
( ) -	( ) -	( ) -

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 - CHILD UNDER AGE 13	C	AC	DC
					AC - CHILD AGE 13 THROUGH AGE 26	C	AC	DC
					DC - DISABLED CHILD	C	AC	DC
						C	AC	DC

SECTION B — *Annual Contribution Amount* (January 1, 2014 - December 31, 2014)*

Health Care Flexible Spending Account	$_____ HCFSA	Annual Contribution: Minimum $260 - Maximum $2,500

* 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	Annual Contribution: Minimum $500 - Maximum $5,000 (**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: / /

DeCAP and HCFSA - 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 or 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)

***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 January 1, 2014. 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, unless I elect to participate in the Continuation Coverage for HCFSA.

Direct Deposit Authorization

I hereby authorize the Tax-Favored Benefits 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 Tax-Favored Benefits 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 Tax-Favored Benefits Program a written cancellation to terminate the service. I will notify the Tax-Favored Benefits 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: / /

Return completed form to:

Tax-Favored Benefits Program - FSA 2014
40 Rector Street, 3rd Floor
New York, NY 10006-1705

Retain a copy for your records

DO NOT WRITE IN THIS AREA

Payroll					Database		Agency Payroll Code
Program	Initials	Date	PMS DOC#	Other Payroll	Initials	Date	
DeCAP		/ /				/ /	
HCFSA		/ /				/ /	

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

PLAN YEAR 2014 ENROLLMENT/CHANGE FORM
FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM

40 Rector Street, 3rd Floor, New York, NY 10006-1705 (212) 306-7760 TTY: (212) 306-7629 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 2014 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). If this section is left blank, a reimbursement check will be sent to the address indicated on the attached form.

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.

Employees Terminating Employment/Unpaid Leave of Absence

- Should my employment terminate with the City of New York, 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) 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) on a pre-tax basis, I will notify the FSA Program Administrative Office in writing 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.
- 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 I will receive a confirmation letter(s) for HCFSA and/or DeCAP when my Enrollment Form has been processed. If I do not receive a confirmation letter(s), or do not experience accurate payroll deductions, I understand that 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.**

PLAN YEAR 2014 ENROLLMENT/CHANGE FORM

MEDICAL SPENDING CONVERSION (MSC)

HEALTH BENEFITS BUY-OUT WAIVER PROGRAM

(212) 306-7760 TTY: (212) 306-7629 nyc.gov/fsa

Employee (Participant) return completed from to:

Agency Benefits Office, NYCAPS Central or HR Share Services Office. See information in Section V and instructions on reverse side.

INSTRUCTIONS: Please review the MSC Health Benefits Buy-Out Waiver section in the Flexible Spending Accounts (FSA) Program Brochure which is on the FSA Website at nyc.gov/fsa. Also, see instructions on reverse side of this form before completing.

ENROLLMENT ***(Check one):***

❑ Open Enrollment (September 9 - October 18, 2013; effective January 1, 2014) Complete Sections I, II, and IV.

❑ Mid-Year Enrollment (January 1 - November 15, 2014; effective Qualifying Event date) Complete Sections I, II, III, and IV.

I. EMPLOYEE (PARTICIPANT) INFORMATION (Please Print)

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

HOME ADDRESS - NUMBER AND STREET	APT

CITY	STATE	ZIP CODE + FOUR
		-

HOME PHONE NUMBER	WORK PHONE NUMBER	MOBILE PHONE NUMBER	E-MAIL
( ) -	( ) -	( ) -	

AGENCY NAME (NOT DIVISION) CUNY AND HHC EMPLOYEES PLEASE SPECIFY THE NAME OF COLLEGE OR HOSPITAL

II. MSC HEALTH BENEFITS BUY-OUT WAIVER PROGRAM SECTION: If completing this section during mid-year, you must also complete Section III below.

A) ***To participate*** in the Buy-Out Waiver Program, complete this form and a Health Benefits Application. Return both forms to your agency's Human Resources Department/NYCAPS (if applicable) for approval and completion.

❑ **I wish to participate in the Buy-Out Waiver Program.** Check *one*

❑ Individual Coverage ($500) ❑ Domestic Partner/Civil Union Coverage ($500) ❑ Family Coverage ($1,000)

Non-City group health plan provider (company name) _____

Please note: You must attach proof of non-City health coverage (letter or health insurance card).

B) ***To terminate*** your participation in the Buy-Out Waiver Program, you must complete this form and a Health Benefits Application for reinstating City health benefits. Return both forms to your agency's Human Resources Department/NYCAPS (if applicable) for approval and completion.

❑ **I wish to withdraw from the Buy-Out Waiver Program.**

III. MID-YEAR QUALIFYING EVENT: Newly eligible employees or current employees changing their status during mid-year must complete this section.

This is to certify that I incurred the Qualifying Event indicated below and, therefore, wish to modify my benefits as indicated. I understand that the change(s) requested must be consistent with the Qualifying Event and that I must submit this form with legal/supporting documentation of all changes to my agency's Human Resources Department/NYCAPS (if applicable) and they must be received by the MSC Administrative Office within 30 days after the Qualifying Event to take effect.

Date of Qualifying Event: ____/____/ 2014 | Today's Date: ____/____/ 2014

If Today's Date is more than 30 days from the Date of Qualifying Event, please note that you are not eligible for Plan Year 2014.

Please check one of the following:

Employment Status: Documentation must be provided by employer/agency

❑ Beginning/termination of employment (❑ self ❑ spouse)
❑ Unpaid leave of absence (❑ self ❑ spouse)
❑ Return from unpaid leave of absence (❑ self ❑ spouse)
❑ Change from P/T to F/T employment or vice versa (❑ self ❑ spouse)
❑ Increase in health plan deductions by more than 20%

Family Status Change: Legal documentation must be provided by participant

❑ Marriage/domestic partner
❑ Birth or adoption of child
❑ Divorce
❑ Ineligibility of dependent (❑ age ❑ marriage)

IV. Employee Signature

I have read the MSC Program materials and instructions and I attest that I meet the qualifications to enroll or withdraw from the MSC Health Benefits Buy-Out Waiver Program.

Signature:_____ Date: ____/____/____

V. FOR COMPLETION BY EMPLOYING AGENCY'S HUMAN RESOURCES DEPARTMENT/NYCAPS PERSONNEL ONLY:

Please review the above information and submitted documentation from employee before completing the information below.

Note to Benefits/Payroll/NYCAPS/HR Share Officer: Send this MSC Form and the Health Benefits Application, along with any legal/supporting documentation, to: MSC Administrative Office, 40 Rector Street, 3rd Floor, New York, NY 10006. You should retain a copy of this form for your records.

- **If your agency is a centralized agency - send directly to: NYCAPS Central, 1 Centre Street, New York, NY 10006**
- **DOE Employee/Payroll/Secretary - send directly to: DOE MSC Unit, 65 Court Street, #101, Brooklyn, NY 11201**
- **HHC Centralized Agency - send directly to: H.R. Shared Services, 160 Water Street, 17th Floor, New York, NY 10038**

1) ***For the Health Benefits Buy-Out Waiver Program*** (Section II), I have reviewed and processed the Health Benefits Application and certify that the employee has listed a non-City group health insurance policy under which he/she is covered. I have notified the appropriate health carrier of this change.

2) ***For mid-year changes, I certify that a Qualifying Event*** listed in Section III has occurred within 30 days after this request *and* this form, along with legal/supporting documentation, have been submitted.

Employee's Agency Appointment Date: ____/____/____ Effective Date of Health Benefits: ____/____/____

A) **MSC Buy-Out Waiver Effective Date: (Check one)**

❑ Open Enrollment: (September 9 - October 18, 2013: effective January 1, 2014)

❑ Mid-Year Enrollment: ____/____/ 2014 (January 1, 2014 - November 15, 2014)

(June 1- June 30, effective July 1, 2014) (December 1- December 31, effective January 1, 2015)

B) **MSC Buy-Out Waiver Withdrawal Date: (Check one)**

❑ Open Enrollment: (September 9 - October 18, 2013: effective January 1, 2014)

❑ Mid-Year Withdrawal: ____/____/ 2014 (January 1, 2014 - November 15, 2014)

AGENCY BENEFITS MANAGER/NYCAPS/HR SHARE PERSONNEL SIGNATURE	EFFECTIVE DATE	WORK PHONE NUMBER
	/ /	( ) -

EMPLOYEE AGENCY CODE	E-MAIL ADDRESS

MSC ADMINISTRATIVE OFFICE USE ONLY

ENROLLMENT EFFECTIVE DATE	WITHDRAWAL EFFECTIVE DATE	PROCESSING DATE	PROCESSOR	AGENCY PAYROLL CODE
/ /	/ /	/ /		

MEDICAL SPENDING CONVERSION (MSC)
PLAN YEAR 2014

INSTRUCTIONS:

HEALTH BENEFITS BUY-OUT WAIVER PROGRAM - SECTION II:

The Medical Spending Conversion (MSC) Health Benefits Buy-Out Waiver Program allows you to receive an incentive payment for waiving your City health benefits. Refer to the MSC Health Benefits Buy-Out Waiver Program section in the Flexible Spending Accounts Program Brochure for detailed information.

A. Enrolling:

Please Note: The Internal Revenue Service does not permit any retroactive participation from a previous Plan Year.

If you are covered under your spouse's/domestic partner's or parent(s)' non-City group health insurance, or a group health plan available through other employment, you may waive New York City health benefits. Once your enrollment form has been processed and approved, you will receive a confirmation letter from the MSC Administrative Office. Please contact your agency's Human Resources Department/NYCAPS/HR Share personnel if you do not receive a confirmation letter.

Current employees: You may enroll in the Program during the Open Enrollment Period (September 9 - October 18, 2013) for an effective date of January 1, 2014. You must complete Sections I, II, and IV. Section V is to be completed by your agency's Human Resources Department/NYCAPS/HR Share personnel.

Newly eligible employees: You may enroll in the Program within thirty (30) days after becoming eligible for City health benefits. You must complete Sections I, II, III, and IV. Section V is to be completed by your agency's Human Resources Department/NYCAPS personnel.

During mid-year: If you incur a Qualifying Event, you must notify the MSC Program Administrative Office within thirty (30) days after the Qualifying Event in order to participate. You must complete Sections I, II, III, and IV and attach legal/ supporting documentation. Section V is to be completed by your agency's Human Resources Department/NYCAPS/HR Share personnel.

Any MSC Form received in June will be effective July1st of that Plan Year. Any MSC Form received in December will be effective January 1st of the following Plan Year.

By signing the MSC Health Benefits Buy-Out Waiver Program Enrollment/Change Form, you elect to receive $1,000 (family coverage waived), $500 (individual coverage waived), or $500 (domestic partner/civil union coverage waived) annually in lieu of New York City health benefits. You will receive $500 for family coverage, $250 for individual coverage, or $250 for domestic partner/civil union coverage waived at the end of every six-month calendar period. Please note that same sex marriage will be treated as family coverage **(This amount will be pro-rated for any period less than six months by the number of days you are in the Health Benefits Buy-Out Waiver Program.)**

An employee participating in the City's Deferred Compensation Plan (DCP) in lieu of FICA and participating in the Health Benefits Buy-Out Waiver Program (taxable income), may need to increase his/her salary deferral percentage to an amount higher than 7.5% of annual salary in order to account for the increase in income due to the "Buy-Out Waiver Incentive Payment." If the 7.5% of total salary income requirement is not met, the participant who is enrolled in the DCP may have to continue to pay FICA taxes until that requirement is met.

B. Terminating:

Your waiver will remain in effect during the Plan Year unless a) you experience an approved mid-year Qualifying Event or, b) you reinstate your City health coverage during the Health Benefits Program Fall Transfer Period. During the mid-year, your form must be received by the MSC Administrative Office within thirty (30) days after the Qualifying Event in order for the change to be effective. If you are returning from an approved leave of absence or transferring to a new City agency, you must complete the MSC Health Benefits Buy-Out Waiver Program Enrollment/Change Form and the Health Benefits Application within thirty (30) days after such event to be reinstated, or to receive a pro-rated incentive payment.

If you wish to terminate your participation in the Health Benefits Buy-Out Waiver Program and reinstate your City health benefits coverage, complete Section II, by indicating your requested change. If you are terminating your participation mid-year, you must also complete Section III.

Please Note: If you waive City health coverage, you must have other non-City group health coverage available to you. The Health Benefits Application must accompany this MSC Form so that your agency's benefits/payroll manager is able to verify that you have other coverage. Your agency's Human Resources Department/NYCAPS/HR Share personnel may request additional documentation.

This form is not valid if you have not completed Sections I, II, III (for mid-year Qualifying Event) and IV.
This form is not valid if Section V has not been completed by your agency's Human Resources Department/NYCAPS/HR Share personnel.

Please return the completed form and documentation to:

- If your agency is a non-centralized agency - send directly to your agency benefits office.
- If your agency is a centralized agency - send directly to: NYCAPS Central, 1 Centre Street, New York, NY 10006.
- DOE Employee/Payroll/Secretary - send directly to: DOE MSC Unit, 65 Court Street, #101, Brooklyn, NY 11201.
- HHC Centralized Agency - send directly to: H.R. Shared Services, 160 Water Street, 17th Floor, New York, NY 10038.

2014 Salary Reduction Agreement

Employee Name: _____

Address: _____

_____

College: _____

CUNYfirst Employee ID: _____

Telephone Number: _____

Date of Hire: _____

Year of Birth: _____

2014 Maximum Deferral Limit: _____%

Based on a projected
2014 annual salary of: $ _____

2014 Contribution Limits

Under age 50.....$17,500

Age 50 or over.....$23,000

The undersigned parties agree that the employee ("you") will participate in the CUNY Tax-Deferred Annuity Program; and that, with respect to amounts paid on or after _____, which is after the date this Agreement is signed, your salary shall be reduced by the amount indicated below, and the employer will contribute that salary reduction amount to your tax-deferred annuity account.

You must specify a salary reduction percentage (in whole or fractional percentages) in the space provided below or this Salary Reduction Agreement will not be valid. Salary reductions to the tax-deferred annuity are made after all other mandatory CUNY deductions.

This Agreement shall be legally binding and irrevocable as to each of the parties hereto while employment continues and will only cover amounts paid while in effect. It will remain in effect unless it is revised or terminated, and no annual renewal is required. This Agreement may be terminated or modified by either party as of the end of any month with at least 60 days prior written notice. Only two modifications can be made to this Agreement during a calendar year; however, this Agreement may be terminated during a year even if two prior modifications have been made. You may not contribute to more than one tax-deferred annuity account at a time.

You agree to hold the City University of New York harmless under this Agreement, provided that any and all sums withheld by the employer pursuant to this Agreement are remitted to the insurer you designated to purchase non-forfeitable contracts in accordance with Section 403(b) of the Internal Revenue Code of 1986 as amended.

The salary reduction maximum percentage listed above is an estimate based upon your projected salary for this year and assumes contributions to one investment provider. Please contact your selected investment provider at the number provided below for a recalculation of your maximum limit if: you have made tax-deferred contributions to another investment provider, including transfers between investment providers; if you are or have been employed on a part-time basis; if you have had a break in service; if you have transferred from one CUNY campus to another; you are or have been on a leave of absence; if you receive income from CUNY in addition to your base salary; or if you are planning to retire this year.

I elect to participate in the CUNY Tax-Deferred Annuity Program account issued by or through (select one):

☐ TIAA-CREF (800 842-2252 [For Instructional Staff, Executive Compensation Plan and Classified Managerial Staff])

☐ HRC Investment Services, Inc.(Halliday Financial Group) (800 786-1598 [For Instructional Staff, Executive Compensation Plan and Classified Managerial Staff])

☐ MetLife (212 840-8610 [For Classified Staff Only])

I elect to reduce my annual salary by _____% provided that this percentage does not exceed the maximum allowed by Section 415 and 402(g) of the Internal Revenue Code as listed above, whichever is less, and the annual amount to be deferred is not below $200. If I am age 50 or older during the year, the maximum deferral limit listed above will include the additional catch-up contribution permitted under Section 414(v) of the Internal Revenue Code. If I elect the maximum deferral permitted under the Internal Revenue Code, my deferral will be increased in subsequent years if the permissible maximum deferral amount is increased.

EMPLOYEE:

Print Name: _____

Signature: _____

Date: _____

CUNY:

By: Leslie E. Williams

Leslie E. Williams
University Executive Director
Shared Services

Important Note: This Salary Reduction Agreement should be returned to your campus Benefits Office.

The United States Life Insurance Company in the City of New York

APPLICATION FOR TERM LIFE INSURANCE

Home Office
(Herein called the Company)
Administrative Office: P.O. Box 9186, Des Moines, Iowa 50306-9186

MEMBER BENEFITS nysut Working to Benefit You

1. NYSUT Member's Name _____ NYSUT Member's Social Security # _____

2. Applicant's Name _____

3. I am ☐ NYSUT member ☐ Spouse ☐ Domestic Partner*

4. Applicant's Address _____
Number Street City State Zip Code

5. Name and Address of Applicant's Physician _____

6. Home Phone No. (_____)_____ Work Phone No. (_____)_____

7. Name of Applicant's Beneficiary _____ Relationship _____

Unless otherwise requested, your beneficiary will be your spouse, if living. Otherwise, your beneficiary will be your children, parents, siblings or estate in that order. Unless otherwise requested, the applicant will be the beneficiary for child coverage.

8. Check Life Insurance plan(s) desired: Amount:

☐ Life Insurance for applicant _____ units**

☐ Life Insurance for child(ren)+ $25,000

☐ Please increase my current Term Life Insurance coverage by $ _____. I understand that to apply for this increase, my answers to the three health questions are usually all that is required, unless my total amount of coverage exceeds $200,000.

Up to $1 million in coverage is available, if under age 65. Contact the Plan Administrator for more details and rates.

Unmarried dependent children are eligible for $25,000 of coverage, subject to state variation. One economical premium covers all eligible dependent children, no matter how many are being covered.

9. Complete the following for the applicant and children+ for whom coverage is requested.

Insured	Name	Age	Date of Birth (MM/DD/YR)	Place of Birth	Height Ft. In.	Weight Lbs.	Sex M	Sex F
Applicant					ft. in.	lbs	☐	☐
Child					ft. in.	lbs	☐	☐
Child					ft. in.	lbs	☐	☐

The United States Life Insurance Company in the City of New York

Please answer these brief questions. **Applicant**

1. Have you ever had, been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys, blood or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; drug or alcohol abuse; diabetes; cancer or tumor; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for an immune disorder excluding HIV? ☐ Yes ☐ No
2. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those stated above? ☐ Yes ☐ No
3. Are you now taking prescription medication or receiving medical attention? ☐ Yes ☐ No

For "Yes" answers to questions 1-3 above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes" in the box at the right ☐ Yes ☐ No

Question #	Applicant	Condition	Date Occurred	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

EXISTING AND PENDING INSURANCE SECTION Life Insurance in Force and/or Pending on Proposed Insured's Life, including Business Insurance: (If none, check "None".) ☐ None

Name of Company	Type of Coverage	Life Amount	Accidental Death	Year Issued	Do you plan to replace this coverage? Yes	No

The United States Life Insurance Company in the City of New York

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

+Dependent Children must be unmarried, up to 23 years of age.

Important Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **(This warning does not apply to application for life insurance in New York.)**

A copy of this application will be attached to and made a part of your certificate.

Applicant's Signature _____ **Date**_____

G-19430 NY 3 Group Policy No. G 233,615 and G-170,468 1/11
AG-8163

Please print or type all information, and answer all questions to avoid processing delays.

Please answer the following:

☐ Payroll deduction (If choosing this option, return the enclosed "Payroll Deduction Authorization Form" with your application.)
Includes automatic 15 percent discount and complimentary Travel Accident protection.

☐ Pension deduction (If choosing this option, return the enclosed "Pension Deduction Authorization Form" with your application.)
Includes automatic 15 percent discount and complimentary Travel Accident protection.

☐ Individual semiannual billing

Applicant's Email Address_____
(for alerts, special notifications and offers)

Please note: Appendix 11 (enclosed) for applicant must be filled out, signed, dated, and returned with the application.

*If applying as a Certified Domestic Partner, please complete the enclosed affidavit.

Your age determines the maximum amount of coverage that you may apply for under the United States Life Term Life Plan. Only those under age 85 may apply. Applicants under age 65 may apply for up to $1 million (200 units) of insurance [a minimum of $25,000 (5 units) must be purchased]. Applicants ages 65-69 may apply for $30,000 (10 units); ages 70-74 may apply for $20,000 (8 units); ages 75-79 may apply for $10,000 (4 units); and ages 80-84 may apply for $5,000 (2 units). Premiums are based on age at date of issue and on anniversary dates. Premium increases when the participant enters a new age bracket. **Note: For ages 18-64, the unit value is $5,000; for ages 65-69, the unit value is $3,000; and for ages 70-84 the unit value is $2,500.

Dependent child(ren) can be insured under the member's insurance or a lawful spouse's (or domestic partner's) insurance, but not both.

United States Life's Term Life Insurance Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits has an endorsement arrangement of 7.61% of earned premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. The Insurer pools the premiums of Member Benefits participants who are insured for the purposes of determining premium rates and accounting. Coverage outside of this plan may have rates and terms that are not the same as those obtainable through Member Benefits. The Insurer or Member Benefits may hold premium reserves that may be used to offset rate increases and/or fund such other expenses related to the plan as determined appropriate by Member Benefits. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

Agency fee payers to NYSUT are eligible to participate in NYSUT Member Benefits-endorsed programs.

For Office use only:

NYSUT DB 14212/14214/1009/48774-S
NYSUT PRD 12380/12381/1010/48774
UFT DB 19630/19631/1003/48775-S
UFT PRD 19058/19059/1004/48775
NYSUT DB RET 19048/19049/1011/48774-S
NYSUT PEN RET 18915/18916/1012/48774

ADMINISTRATOR
Marsh U.S. Consumer,
a Service of Seabury & Smith, Inc.
P.O. Box 9186
Des Moines, IA 50306-9186
Our hearing-impaired or voice-impaired members may call the Relay Line at 1-800-855-2881.
QUESTIONS?
Call: 1-888-386-9788
customerservice@marshpm.com

This Notice must be detached and retained by the applicant

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information from its file to other insurance companies to which you may apply for life or health insurance, or to which a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MIB-19431

Domestic Partnership Declaration

Name of Applicant _____

Name of Domestic Partner _____

The undersigned member and domestic partner, being of sound mind, hereby state the following:

1. That the undersigned member and domestic partner have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations and that this commitment is of at least six months duration and is expected to continue indefinitely.
2. That the undersigned member and domestic partner share a single permanent residence (attach one copy of evidence such as driver's license).
3. That the undersigned member and domestic partner are financially interdependent as demonstrated by at least two of the following (check all that apply and attach copy of evidence):
   - ❑ Common ownership of a motor vehicle.
   - ❑ Joint bank or credit accounts.
   - ❑ Assignment of durable power of attorney in favor of one another.
   - ❑ Common ownership of real estate or common leasehold interest in property.
   - ❑ Joint ownership or holding of stocks, bonds, or other investments.
   - ❑ Execution of will naming each other as executor and/or beneficiary.
   - ❑ Designation as beneficiary under the other's retirement or pension benefits account.
4. That the undersigned member and domestic partner (check one):
   - ❑ have filed a domestic partner declaration with the (City/Council/Borough) of_____ and that such domestic partner declaration remains in effect (attach copy of declaration).
   - ❑ do not reside in a jurisdiction which provides for the registration of domestic partnership declarations.
5. That neither the undersigned member nor domestic partner would be able to affirm questions 1 through 4 above with respect to any person except the other.
6. That neither the undersigned member nor domestic partner has executed or filed a declaration or affidavit of domestic partner status with any other person within the past 12 months.
7. That the undersigned member and domestic partner are each no less than 18 years of age, and are under no legal disability which would prevent them from making this affidavit.
8. That neither the undersigned member nor domestic partner are now, or have been within the past six months, married to any other person, including common law marriage.
9. That the undersigned member and domestic partner are not related by blood in any degree which would prevent their marriage to each other.

The undersigned member and domestic partner represent that the statements made herein are true and correct to the best of their knowledge, information and belief. Member and domestic partner understand that these statements are given for the purpose of establishing their eligibility and understand that any misrepresentation, whether or not made with intent to deceive, may result in the ineligibility of the domestic partner for coverage under such policy, and in the voiding of such coverage. The member and domestic partner agree to furnish upon the Company's request evidence to substantiate any statement made herein, and that the Company may require the member and/or domestic partner, if living, to reaffirm all statements made herein periodically and/or when a claim is submitted. In the event any coverage is voided due to any misrepresentation herein, the Company's liability shall be limited to a return of any premiums paid on behalf of the domestic partner for any period of ineligibility.

Applicant's Signature_____ **Date**_____

Soc. Sec. No._____

Domestic Partner's Signature_____ **Date**_____

Soc. Sec. No._____

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DEFINITION OF REPLACEMENT

Important Instructions

1. One copy of this "Definition of Replacement (Appendix 11)" form is included with your application. In accordance with the Insurance Department of the State of New York's Regulation 60, **this completed, signed and dated Appendix 11 form must be returned with your completed application even if you indicate "None" in the Existing and Pending Insurance section on your application.** Your application for life insurance coverage cannot be processed without this completed, signed and dated form.

2. If you answer "Yes" to any of the questions on this Appendix 11 form, in accordance with the Insurance Department of the State of New York's Regulation 60, the "Important Notice Regarding Replacement OR Change Of Life Insurance Policies Or Annuity Contracts (Appendix 10C)" form will be sent to you for your review. **The Appendix 10C form must be signed, dated and returned, acknowledging you have read and received that notice.**

3. Should you have any questions, please contact the plan administrator. A Certificate of Insurance can not be issued until Appendix 11 and Appendix 10C, if applicable, are completed, signed, dated and returned.

The United States Life Insurance Company in the City of New York

APPENDIX 11:
INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINED WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, PLEASE ANSWER THE FOLLOWING QUESTIONS.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

(1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the Insurer replacing the life insurance policy or annuity contract, or otherwise terminated?

☐ Yes ☐ No

(2) Changed or Modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits; dividend accumulations, dividend cash values or other cash values?

☐ Ye ☐ No

Please continue this form on the reverse side

(3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force?

☐ Ye ☐ No

(4) Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies?

☐ Ye ☐ No

(5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies?

☐ Ye ☐ No

(6) Continued with a stoppage of premium payments or reduction in the amount of premium paid?

☐ Ye ☐ No

The United States Life Insurance Company in the City of New York

If you answered "Yes" to any of the above questions, a replacement as defined by New York Insurance Department Regulation No. 60 has occurred or is likely to occur and you will be provided with the Important Notice Regarding Replacement OR Change Of Life Insurance Policies or Annuity Contracts (Appendix 10C) form.

_____/_____/_____

Applicant's Signature and Printed Name Date

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Be sure that you are making an informed decision. Contact your existing company or its agent for more information about the old policy or contract. If you request one, an inforce illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. (A fee may be charged for your inforce illustration.)

0000214-0000008-0000018

MEMBER BENEFITS
nysut
Working to Benefit You

Term Life Insurance Plan

For All Stages of Life...

If you're young and embarking on an exciting career, settled with a growing family, or retired and enjoying your leisure, life insurance can put your mind to rest about the financial risks that can come at any time. You may be paying off college loans and don't want to leave a financial burden in case of your unexpected death. Or maybe you're starting a new family; purchasing a first home; or buying a boat, camper or vacation property; and you want to make sure you don't leave your bills to your loved ones. Once you retire, you may want to leave something for the kids, your alma mater, or you may simply want enough to pay off any lingering bills in the event of your death.

The NYSUT Member Benefits Trust-endorsed Term Life Insurance Plan can help at any stage of your life. The plan provides coverage through age 84, so there is no need to look for replacement coverage just when your health may be starting to fail. Keep your coverage until you turn age 85.

How many months would your family last on your current life insurance?

Don't gamble with your family's future.

Sufficient life insurance is a smart solution to help assure their financial security. Why not get it the easy, economical way with the Member Benefits-endorsed Term Life Insurance Plan with Accelerated Benefits?

Today you and/or your lawful spouse or certified domestic partner have the opportunity to purchase up to $1 million of life insurance coverage under this plan, if under age 65. Up to $25,000 is available for each of your eligible children, subject to state variation.

The Plan Features Accelerated Benefits

Your certificate provides an Accelerated Benefits provision for insureds under age 70. With the Accelerated Benefits Provision, you can decide to receive up to 60 percent of your life insurance benefit before death if you are diagnosed as terminally ill with less than 12 months to live. These Accelerated Benefits may prove to be essential to pay for final medical costs, or to maintain the financial security of your family during a terminal illness.

The Convenience of Payroll/Pension Deduction

If your local association has made arrangements for payroll deduction of Member Benefits-endorsed programs, you and your lawful spouse or certified domestic partner both qualify for this convenient way to pay your premiums. Likewise, if you are retired and are collecting a monthly pension benefit from NYSTRS, NYSERS, NYCTRS or NYCBERS, or if you are receiving income from a monthly lifetime annuity payment from TIAA-CREF, you and your lawful spouse or certified domestic partner qualify for the convenience of pension deduction. Premiums will automatically be deducted from the NYSUT member's paychecks over 20 or 26 pay periods or from 12 monthly pension benefits. No checks to write ... no payments to remember. Everything is handled automatically for you.

When you retire, your coverage will be put on direct semiannual bill until your retirement system can begin pension deduction. While you are on direct bill awaiting the start of pension deduction, the payroll deduction discounted premium rate will continue for two billing cycles. Pension deduction is always made in 12 equal payments.

Special payroll and pension deduction features include a 15 percent discount on your premiums, and you will automatically receive no-cost travel accident insurance. You will receive Travel Accidental Death and Dismemberment Insurance benefits up to a maximum of $100,000, with an additional $25,000 of AD&D benefits to cover any physical assault while you are involved in an employment-related activity ... all at no extra cost to you.

Details are outlined in these materials. Please take a few minutes to read them thoroughly.

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Important questions and answers about the Member Benefits-endorsed Term Life Insurance Plan with Accelerated Benefits

Q: How do Accelerated Benefits work?

A: Should you or your insured lawful spouse or certified domestic partner be under age 70 and diagnosed as terminally ill (with a life expectancy of 12 months or less), you are eligible to receive up to 60 percent of your life insurance benefit before death. This can be used to help pay medical costs or help maintain financial security during a difficult time.

The minimum benefit is the lesser of $50,000 or 25 percent of your life insurance amount. The maximum benefit is the lesser of $250,000 or 60 percent of your life insurance amount. The remainder of your benefit will be payable to your beneficiary after death. (Children's coverage and coverage for those over age 70 do not include this Accelerated Benefits provision).

There is no added cost for this provision. Full details of this benefit are outlined in your Certificate of Insurance. Receipt of Accelerated Benefits may be taxable. Consult your personal tax consultant for details. To request this benefit you must notify the Insurance Company in writing and submit proof of the terminal illness.

Q: What are the renewability features?

A: Your coverage cannot be cancelled as long as you are under age 85, maintain NYSUT membership or remain the lawful spouse or certified domestic partner of a NYSUT member, pay your premiums when due and the Member Benefits Group Policy remains in force.

Q: What are my conversion rights?

A: If coverage ends for a reason other than nonpayment of premiums, you may convert that coverage amount at any time prior to age 85 for a permanent individual life insurance policy offered by the Insurance Company. You do not need to furnish evidence of good health. Your new policy may be for a like or lesser amount of coverage in force on the date of conversion. Your dependent children are guaranteed conversion when they reach age 23.

Q: What about coverage for my lawful spouse or certified domestic partner and children?

A: Your lawful spouse or certified domestic partner under age 85 may apply for insurance. Applicants under age 65 may apply for up to $1 million in coverage. Each unmarried, dependent child age 15 days to age 23 is eligible for $25,000 of coverage, subject to state variation. Just one low premium covers all your children! Child coverage may be included in either your certificate or your lawful spouse's or certified domestic partner's, but not both. Certified domestic partners should contact the Plan Administrator for an affidavit to prove certification.

Note: A person who is eligible to apply as a member is not eligible to apply as a lawful spouse or domestic partner, i.e., in situations where a NYSUT member's lawful spouse is also a NYSUT member, they may each apply for $1 million in coverage, but one could not apply for $1 million as a member and another $1 million as a lawful spouse of a member.

Q: If I use Payroll or Pension Deduction, how much can I save on premium rates?

A: By choosing to pay premiums through payroll or pension deduction, you can take advantage of rates that are discounted by 15 percent.

Q: If I use Payroll/Pension Deduction, what type of accident coverage do I receive?

A: If you purchase this plan via payroll/pension deduction, you will receive, at no cost to you, Travel Accidental Death and Dismemberment (AD&D) Insurance benefits equal to the amount of your life insurance you select under payroll/pension deduction – up to a maximum of $100,000. Benefits will be paid for a loss that occurs while riding in or entering/exiting from any land or water public conveyance or when traveling as a fare-paying passenger on any scheduled licensed airline flight. An additional $25,000 of AD&D benefits is included for a covered physical assault while you are engaged in an employment-related activity.

These benefits are subject to limitations and exclusions described in these materials. This coverage will end if the group policy ends, if premium is not paid by the policy-holder, or if insurance ends under the life insurance plan.

Q: If I use Payroll Deduction, what happens to my Payroll Deduction life insurance when I retire?

A: As long as you retain your NYSUT membership as a retiree or remain the lawful spouse or certified domestic partner of a NYSUT member, you can maintain your life insurance coverage. Your premium will be transferred from payroll deduction to individual billing on a semiannual basis. Once you start to receive monthly pension benefits, you can change your payment option to pension deduction. While on individual billing awaiting the start of pension deduction, the payroll deduction discounted premium rate will continue for two billing cycles.

Q: If I use Payroll Deduction, can I keep my life insurance coverage if I change employers and my new employer does not offer payroll deduction?

A: Yes! Your payment option will change to individual billing on a semiannual basis. Remember, you must also retain your NYSUT membership or remain the lawful spouse or certified domestic partner or a NYSUT member to maintain your life insurance coverage.

Q: Are there any exclusions?

A: Your Term Life insurance is payable in the event of death from any cause, at any time, in any place, except for suicide within two years of the effective date of your

certificate or within two years from effective date of an increase in your benefit amount. Misrepresentation may invalidate coverage within the first two years from effective date of your certificate or within two years from effective date of an increase in your benefit amount.

Exclusions for the Accelerated Benefits provision are: terminal illness that is the result of an intentional self-inflicted injury or attempted suicide; if you have made an absolute assignment of your life insurance under the policy; all or part of your life insurance is to be paid to your child(ren) or former spouse as part of a court-approved divorce agreement; or written consent is not received from the beneficiary.

Accidental Death and Dismemberment Insurance, provided with the payroll/pension deduction payment option, has a list of exclusions. No benefits will be paid for any loss that results from or is caused directly, indirectly, wholly or partly by:

1. Suicide; or intentionally self-inflicted injury;
2. Insurrection; war or any act of war;
3. A physical or mental sickness, or treatment of that sickness;
4. Voluntary intake of poison, drugs, gas or fumes, unless take as prescribed by a physician;
5. Committing a crime, or an attempt to do so;
6. Being intoxicated or under the influence of any drug, unless taken as prescribed by a physician;
7. Riding as a passenger or otherwise, in any vehicle or device for aerial navigation, except as provided under the "Description of Hazards" in the Schedule of Benefits.

Q: May I return my Certificate if I'm not satisfied?

A: Of course. If after receiving your Certificate you are not pleased 100 percent with the terms of your new coverage, simply return it to the Plan Administrator within 30 days and any money you've paid or had deducted from your paycheck or pension benefit will be refunded in full – no questions asked! **Your satisfaction is assured.**

Two Methods of Premium Payment ... Payroll/Pension Deduction or Individual Billing

If payroll/pension deduction for NYSUT Member Benefits-endorsed programs is available to you and you choose this as your payment option, please follow the instructions and the rates in the payroll/pension deduction section below.

If Member Benefits payroll/pension deduction is not available to you, individual billing on a semiannual basis is available. Please follow the instructions and rates in the individual billing section.

Payroll/Pension Deduction

SEND NO MONEY. To determine what your approximate deduction amount will be: Multiply the deduction amount for your age bracket and deduction schedule by the number of units desired (e.g., for $100,000 at age 39 with 20 deductions, multiply $0.14 by 20 units = $2.80). If you are applying for child coverage, just add $1.70 (for 12 deductions), $1.03 (for 20 deductions) or $0.79 (for 26 deductions) to your payroll/pension deduction amount. ($0.79, $1.03 or $1.70 covers all your dependent children no matter how many.)

Your lawful spouse or certified domestic partner qualifies for payroll/pension deduction through your payroll/pension check. The Payroll or Pension Deduction Authorization Form must be completed by the NYSUT ***member*** and returned with the spouse's or certified domestic partner's application.

Approximate Payroll/Pension Deduction Amount
Rates effective 9/1/2010

Applicant's Age	Life Insurance Per Unit*	Rates Based on 26 Payroll Deductions (UUP, PSC-CUNY)	Rates Based on 20 Payroll Deductions (NYSUT, UFT)	Rates Based on 12 Pension Deductions
Under 30	$5,000	$0.08	$0.10	$0.17
30-34	$5,000	$0.09	$0.12	$0.20
35-39	$5,000	$0.11	$0.14	$0.23
40-44	$5,000	$0.16	$0.20	$0.34
45-49	$5,000	$0.25	$0.32	$0.53
50-54	$5,000	$0.36	$0.46	$0.76
55-59	$5,000	$0.56	$0.72	$1.20
60-64	$5,000	$0.97	$1.26	$2.10
65-69	$3,000	$0.95	$1.23	$2.05
70-74	$2,500	NA	NA	$3.40
75-79	$2,500	NA	NA	$5.69
80-84	$2,500	NA	NA	$9.80
Children	N/A+	$0.79	$1.03	$1.70

Please note: Payroll and pension deduction amounts are approximate due to rounding.

Individual Billing

Send no money now. You will be billed later. To determine what your semiannual premium will be: Multiply the semiannual premium for your age bracket by the number of units desired (e.g., for $100,000 at age 39, multiply $1.62 by 20 units = $32.40). If you are applying for child coverage, just add $12.05 to your semiannual premium. ($12.05 covers all your dependent children no matter how many.)

Semiannual Premium Rates
Rates effective 9/1/2010

Applicant's Age	Life Insurance Per Unit*	Semiannual Direct Bill
Under 30	$5,000	$1.15
30-34	$5,000	$1.39
35-39	$5,000	$1.62
40-44	$5,000	$2.36
45-49	$5,000	$3.72
50-54	$5,000	$5.37
55-59	$5,000	$8.43
60-64	$5,000	$14.80
65-69	$3,000	$14.43
70-74	$2,500	$24.00
75-79	$2,500	$40.00
80-84	$2,500	$69.00
Children	N/A+	$12.05

*Your age determines the maximum amount of coverage you may apply for under the United States Life Term Life Plan. Only those under age 85 may apply. Applicants under age 65 may apply for up to $1 million (200 units) of insurance [a minimum of $25,000 (5 units) must be purchased]. Applicants ages 65-69 may apply for $30,000 (10 units); ages 70-74 may apply for $20,000 (8 units); ages 75-79 may apply for $10,000 (4 units); and ages 80-84 may apply for $5,000 (2 units). Premiums are based on age at date of issue and on anniversary dates. Premiums increase when the participant enters a new age bracket.

Please note: Under age 65, the value of each life insurance unit is $5,000. For ages 65-69, the value of each life insurance unit reduces to $3,000; and for ages 70-84, each life insurance unit reduces to $2,500. Coverage reduces by 40 percent on the billing anniversary date that coincides with or next follows the date the insured attains age 65. Coverage reductions at age 70 depend upon the coverage amount in force at age 69. Benefit amounts of $20,000 or more will reduce to $20,000 at age 70, $10,000 at age 75, and $5,000 at age 80. For those with lesser amounts of existing term life insurance benefits: Benefit amounts of $10,000 to $19,999 will reduce to $10,000 at age 70, $5,000 at age 75, and $2,500 at age 80. Benefit amounts of less than $10,000 at age 70 will continue until equal to or less than the standard age bracket amounts of $5,000 at age 75 and $2,500 at age 80. Coverage terminates at age 85.

If the total amount applied for, plus existing Member Benefits-endorsed Term Life Insurance Plan coverage, equals or exceeds $200,000, and in certain circumstances, a medical examination is required. Along with the medical exam, additional medical information will be required for applicants ages 65 and over.

+Child premium rate is for a total benefit of $25,000 per covered child, subject to state variation.

Any way you pay, you'll save money ... with economical rates!

Why Term Insurance?

Term insurance offers an important advantage over permanent life insurance ... cost! The premium for a term policy is typically less than permanent life insurance.

Why? Because term life insurance does not offer cash, loan, or retirement income values. It provides "pure" insurance protection during the period your spouse and children depend heavily on your income.

Survivor Financial Counseling Service™

This plan provides financial guidance upon your death to a surviving spouse or domestic partner, or to you in the event that you have been diagnosed as terminally ill with a life expectancy of 12 months or less.

This no-cost-to-you benefit offers objective, professional, confidential financial advice from Ernst & Young LLP, financial planners, who neither sell nor have marketing arrangements to recommend financial products or services.

Upon receipt of a death claim, a notice will be sent to your Estate offering this free service to your surviving spouse or certified domestic partner.

Applying for the Member Benefits-endorsed Term Life Insurance Plan is easy ...

Who May Apply?

NYSUT members (excluding associate members – friends of education), agency fee payers, and their lawful spouses or certified domestic partners under age 85 may apply for Member Benefits-endorsed Term Life Insurance. Each applicant must complete a separate application, which will be individually underwritten. Certified domestic partners must contact the Plan Administrator for an affidavit, which must accompany their application. If the total amount applied for, plus existing Member Benefits-endorsed Term Life Insurance Plan coverage, equals or exceeds $200,000, and in certain circumstances, a medical examination is required. Along with the medical exam, additional medical information will be required for applicants ages 65 and over. If additional information is needed, you will be contacted by the underwriting company. **Do not cancel any other life insurance until after you are accepted into this program.**

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In-service members must be actively at work when insurance is to take effect. If not, insurance will take effect on the day the member returns to work. Lawful spouses and retired members must be able to perform the normal activities (as defined by the policy) of a person of like age, sex, or retired status on the date insurance is to take effect. If not, the insurance will take effect on the day one resumes such activities.

If you are also applying for dependent coverage and the dependent is hospitalized on the date his or her insurance is to take effect, it will take effect on the day after he or she is discharged.

Up to $1 Million Available ... at an Economical Price!

With this plan, you and your family have access to up to $1 million of term life protection, if under age 65. The plan's past claims experience has been favorable. Member Benefits has succeeded in ensuring that you benefit from this experience by negotiating economical term life premiums for all age brackets listed in these materials.

How to Apply

1. Complete, date and sign the application.
2. Be sure to indicate the number of life insurance units you desire.
3. **If you choose payroll/pension deduction,** simply complete the enclosed application and mail it along with the appropriate deduction authorization form to the Plan Administrator. Your lawful spouse (or certified domestic partner) also qualifies for payroll deduction through your paycheck or pension deduction through your monthly pension benefit.

If you choose individual billing, simply complete the enclosed application and mail it to the Plan Administrator.

Either way, send no money now; you will be billed later.

4. Mail your application, one copy of Appendix 11 (and the appropriate deduction authorization form, if applicable) to:

Marsh U.S. Consumer Insurance Plans Administrator
P.O. Box 9186
Des Moines, IA 50306-9186

Take advantage of this valuable opportunity now.

Complete the enclosed application. If you are choosing payroll or pension deduction as your payment option, also complete the appropriate deduction authorization form. Or if you would rather choose individual billing, send no money now. Once your application has been approved, a bill will be mailed to you.

Your satisfaction is assured!

Plan Administrator:
MARSH

P.O. Box 9186
Des Moines, IA 50306-9186
Call Toll-Free: 1-888-386-9788

AR Ins. Lic. #245544
CA Ins. Lic. #0633005
d/b/a in CA Seabury & Smith Insurance Program Management

NYSUT MEMBER BENEFITS TRUST DISCLOSURE NOTICE

United States Life's Term Life Insurance Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits has an endorsement arrangement of 7.61% earned premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. The Insurer pools the premiums of Member Benefits participants who are insured for the purposes of determining premium rates and accounting. Coverage outside of this plan may have rates and terms that are not the same as those obtainable through Member Benefits. The Insurer or Member Benefits may hold premium reserves that may be used to offset rate increases and/or fund such other expenses related to the plan as determined appropriate by Member Benefits. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

Agency fee payers to NYSUT are eligible to participate in NYSUT Member Benefits endorsed programs.

Underwritten By:

The United States Life Insurance Company in the City of New York

This is a brief description of coverage underwritten by The United States Life Insurance Company in the City of New York, and is subject to the terms, conditions, exclusions and limitations of Group Policy Nos. G-233, 615, and G-170,468, Form No. G-19000. Please see your Certificate of Insurance for details.

The underwriting risks, financial and contractual obligations and support functions associated with the products issued by the United State Life Insurance Company in the City of New York are its responsibility.

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NYSUT MEMBER BENEFITS PAYROLL DEDUCTION AUTHORIZATION

(Please Print)

Member's Last Name | First Name | Middle Initial | Member's Social Security No.

Street Address | City | State | Zip | Home Telephone No. ( )

Please check your union membership affiliation:

❑ *UFT* ❑ *UUP* ❑ *PSC/CUNY** ❑ *All other NYSUT Locals*

This authorization form cannot be used to authorize deductions for PSC-CUNY Welfare Fund Benefits.

The amount of deduction will be determined by the NYSUT Member Benefits Trust based on the programs chosen.

To the Employer: *I hereby authorize you to deduct from each of my salary checks the deduction necessary for the purpose of the NYSUT Member Benefits. Depending on the program deductions are taken for, monies will be forwarded to either NYSUT Member Benefits Trust or NYSUT Member Benefits Corporation, which are entities under the NYSUT Member Benefits umbrella. I understand that this authorization may be revoked at any time by written notice to you.*

Signature of Employee _____ **Date** _____

NYSUT Member Benefits - 800 Troy-Schenectady Road, Latham, NY 12110-2455

CUT HERE

NYSUT MEMBER BENEFITS PENSION DEDUCTION AUTHORIZATION

(Please Print)

Last Name _____ First _____ Initial _____

Address _____

Home Telephone No. ( ) _____

Social Sec. No. _____ Authorization is for _____ (name of plan)

Read statements below. Signature and date are required.

NYSUT MEMBER BENEFITS - 800 Troy-Schenectady Road, Latham, NY 12110-2455

Retirement/Pension Number for NYSERS and TIAA-CREF Participants:

If you belong to NYS Employees' Retirement System, please enter your retirement/pension number below. If you are a TIAA-CREF annuitant, please enter your TIAA contract number and CREF certificate number below.

_____

CHECK ONE BOX ONLY – SIGN AND DATE BELOW

❑ I belong to the Teachers' Retirement System of the **CITY of New York** (TRS) and I hereby request a monthly withholding of deductions from my monthly benefit for the purchase of union-sponsored benefits as permitted by Chapter 248, Laws of 1994. The TRS is authorized to continue taking such deductions until NYSUT Member Benefits Trust receives written notice from me to the contrary.

❑ I belong to the New York City Board of Education Retirement Systems (BERS).

❑ I belong to the NYSUT Staff Pension Program.

❑ I belong to the New York **STATE** Teachers' Retirement System (NYSTRS), or

❑ New York **STATE** Employees' Retirement System (NYSERS) and I hereby request monthly withholding of union deductions from my monthly benefits as permitted by Section 536 of the Education Law and Section 110-C of the Retirement Social Security Law. NYSTRS or NYSERS is authorized to continue taking such deduction until NYSUT Member Benefits Trust receives written notice from me to the contrary.

❑ I am a TIAA and/or CREF annuitant and hereby request a monthly withholding of deductions from my monthly TIAA and/or CREF income for the purchase of coverages provided through NYSUT Member Benefits' Pension Advantage program. TIAA-CREF is authorized to continue taking such deductions until Member Benefits receives written notice from me to the contrary. If at any time the total deductions equal or exceed my combined monthly income payments from TIAA-CREF, all deductions I have authorized TIAA-CREF to take on my behalf will terminate immediately.

I expressly acknowledge and understand that NYSUT Member Benefits Trust will determine the exact deduction to be withheld monthly and that any questions regarding the amount will be directed by me to Member Benefits. Depending on the program deductions are taken for, monies will be forwarded to either NYSUT Member Benefit Trust or NYSUT Member Benefits Corporation, which are entities under the NYSUT Member Benefits umbrella. I hereby certify to TRS, NYSTRS, NYSERS or TIAA-CREF that I am a member of NYSUT, an employee organization entitled to receive union deduction payments as providers by law.

Signature _____ *Date* _____

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