

Borough of Manhattan Community College The City University of New York www.bmcc.cuny.edu 199 Chambers Street New York, NY 10007-1097 tel. 212-220-8300 fax 212-220-2364

Dear New Employee:

Welcome to BMCC. Attached are a variety of documents concerning your appointment to the college that you need to be aware of or must complete. Please read these materials carefully and provide all of the requested information as quickly as possible.

We hope you will enjoy your experience at the college. Best wishes for a productive and successful career at BMCC.

Sincerely,

Robert E. Diaz

Vice President of Legal Affairs and

Faculty & Staff Relations



Borough of Manhattan Community College The City University of New York www.bmcc.cuny.edu 199 Chambers Street New York, NY 10007-1097 tel. 212-220-8300 fax 212-220-2364

Full Time Instructional Staff/Faculty/ECP Packet Checklist

When you accept an offer of employment with the Borough of Manhattan Community College, you must present ORIGINAL documents as outlined below.

		Verification (I-9) form in the presence of an HR
Social Security Card		Agency Shop Agreement
Curriculum Vitae (Faculty)		Health Benefits Application
Three letters of reference		PSC-CUNY Welfare Fund Datasheet
Original Transcript (highest degree)		Retirement Program Election Form
Employment Packet – CUNY		Death Benefit Beneficiary Designation Card
Personnel Information Form		Emergency Contact
Amended Constitutional Oath Upon Appointment		Employee's Withholding Allowance Certificate (W-4 and IT-2104)
applicable, complete and return:		
Direct Deposit of Net Pay Enrollment Tax Certification for Foreign Nationals		Transit Benefit Enrollment/Wage Works)
ease take time to familiarize yourself with the foll	lowing:	
Iealth Plan costs and optional riders, etc.		IAA-CREF enrollment instructions
Departmental Mailboxes and E-mail Accounts		isting of various policies/procedures on BMCC Web.
int Name	Da	te
unature		
	Under federal law you must complete an Emp officer. Be sure to bring appropriate proof of Social Security Card Curriculum Vitae (Faculty) Three letters of reference Original Transcript (highest degree) Employment Packet – CUNY Personnel Information Form Amended Constitutional Oath Upon Appointment applicable, complete and return: Direct Deposit of Net Pay Enrollment Tax Certification for Foreign Nationals case take time to familiarize yourself with the foll lealth Plan costs and optional riders, etc. a comparison of pension plans Departmental Mailboxes and E-mail Accounts te timing of your initial pay check will be based of you have any questions about your appointment of the surface of th	Curriculum Vitae (Faculty) Three letters of reference Original Transcript (highest degree) Employment Packet – CUNY Personnel Information Form Amended Constitutional Oath Upon Appointment applicable, complete and return: Direct Deposit of Net Pay Enrollment Tax Certification for Foreign Nationals case take time to familiarize yourself with the following: Itealth Plan costs and optional riders, etc. A comparison of pension plans Departmental Mailboxes and E-mail Accounts e timing of your initial pay check will be based on the proyou have any questions about your appointment or payroll int Name Da

BOROUGH OF MANHATTAN COMMUNITY COLLEGE

The City University of New York IMMIGRATION REFORM AND CONTROL ACT OF 1986

EMPLOYMENT ELIGIBILITY VERIFICATION INFORMATION

Among other changes, the Immigration Reform and Control Act of 1986 creates a national employment verification system which places responsibility for verification of the identity and employment eligibility of all employees on the employer. Effective June 1, 1987 this new law requires employers to request and examine original documentation pertaining to the identity and employment eligibility of all new hires and rehires, including U.S. citizens, permanent residents, and non-immigrant visa holders.

Should you accept an offer of employment with the Borough of Manhattan Community College, you must present **ORIGINAL** documentation, outlines on the next page of the document, on or before your first day of work.

After these documents are reviewed, you will then be required to complete and sign an Employment Eligibility Verification Form (Form 9) in the presence of the designated representative of the College.

Should you accept an offer of employment with the College, this process should be completed on or before your first day of work. Otherwise, your employment at the College will be jeopardized.

If you have any questions concerning the employment process at Borough of Manhattan Community College, please call **Human Resources Office**, **212-220-8300**

Borough of Manhattan Community college Office of Human resources Personnel Information form

Name (print)				Social Security Number	_
Title		 Dep	artment	Date of Appointment	
☐ Fe	emale	☐ Male	Date of Birth	<u> </u>	
Ethnicity:					
☐ An	nerican Indian	□ A	laskan Native	☐ Asian	
☐ Bla	ack	☐ Hispanic		☐ Italian American	
☐ Pa	cific Islander	□ P	uerto Rican	☐ White	
U.S. Citizen:	☐ Yes	□ No	If you are no	t a U.S. Citizen,	
Of wh	nat country are y	ou a citizen: _			
What	type of VISA are	you holding:		Expiration Date:	
Are you a Vet	eran? 🗆 Y	'es □ N	lo If yo	u are a veteran, please specify:	
□ Ac	tive Reserve		isabled	☐ Disabled Vietnam Era	
☐ Ina	active Reserve	□R	etired	☐ Vietnam Era	
Home Addres (print)	s:				
Telephone Nu	ımber: ———				
Emergency Co	ontact:		Rela	tionship:	
Address:					
Telephone Nu	ımber:		Busii	ness Number:	
Education:	<u>Degree</u>	Major	Date Earned	<u>Institution</u>	
		To be cor	npleted by the O	ffice of Human Resources	
I-9 Date:		Work Authoriza	tion Expiration D	ate:Staff Initial	Date:



Name	
Position	
College	
Dept.	

THE CITY UNIVERSITY OF NEW YORK EMPLOYMENT APPLICATION - PART TWO POST-CONDITIONAL OFFER OF EMPLOYMENT

This form should be completed only after a conditional job offer has been made.

Accommodation required to perform Essential Job Functions

It is the University's policy to provide reasonable accommodations, when appropriate, to individuals with disabilities, individuals observing religious practices, employees who have pregnancy or child-birth related medical conditions, or employees who are victims of domestic violence/stalking/sex offenses.

If you require an accommodation to perform the essential job functions for the position for which you have received a conditional offer of employment, please contact the HR Director.

Confidential Criminal Background Information

As a candidate with a conditional offer of employment, you must provide criminal background information for our review.

A conviction record will not necessarily disqualify you from the position for which you are applying. However, failure to provide truthful responses will, when discovered, automatically result in the withdrawal of the conditional offer of employment or your termination, if employed.

In accordance with Article 23-A of the New York State Corrections Law, the following factors shall be considered concerning previous criminal convictions:

- the public policy of New York State, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses
- the specific duties and responsibilities necessarily related to the license or employment sought or held by the person
- the bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his/her fitness
 or ability to perform one or more such duties or responsibilities
- the time which has elapsed since the occurrence of the criminal offense or offenses
- the age of the person at the time of occurrence of the criminal offense or offenses
- the seriousness of the offense or offenses
- any information produced by the person, or produced on his behalf, in regard to his/her rehabilitation and good conduct
- the legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public

Before any adverse action is taken based on a previous criminal conviction, CUNY will

- furnish a written copy of the criminal history inquiry to the candidate in a manner determined by the New York City Commission on Human Rights ("NYCCHR")
- provide a written Article 23-A analysis to the candidate in a form determined by the NYCCHR, together with supporting
 documents which formed the basis and reasons for the adverse action; and
- after providing the candidate with the required documentation, allow him or her at least three business days to respond
 and, during that time, hold the position open for the candidate.



THE CITY UNIVERSITY OF NEW YORK

APPLICATION FOR EMPLOYMENT - PART TWO

Application for Employment - Part Two (Confidential Background Information)
Only candidates who have received a conditional job offer should complete this form.

For questions and concerns, candidates may request guidance from the Office of Human Resources.

The completed form should be submitted to the Office of Human Resources only.

	The completed form should be submitted to the Office of Human Resources only.
College	Job ID# Full-time
Position	Part-time
Contract	t A.M.
Title	P.M.
Persona	al Information
Last Nan	ne First Name Middle Initial
If known	n by another name, please provide
Address	Apt.#
City	State Zip Code Daytime Phone #
e-mail	Evening Phone #

Please complete Page 3

Confidential Criminal Background Information:									
1. Have	1. Have you ever been convicted of an offense anywhere, including felonies, misdemeanors or penal law violations?								
<u>DO NOT</u> include traffic violations or convictions sealed, expunged, or set aside under federal law or state law. However, you are required to disclose all other criminal convictions, even if you have a Certificate of Relief from Disabilities or a Certificate of Good Conduct in connection with one or more offenses. If you have a Certificate of Relief from Disabilities or a Certificate of Good Conduct, please provide it with this form.									
2. Are th	ere any crim	inal charges or	penal law viol	lations (except	for traffic violations) currently	pending again	st you?	Yes No
		ow <u>all</u> past con pages, as nece		rently pending	g criminal charges ag	gainst you (a	as specified in (Questions 1 a	nd 2 above).
Offense			Date of conviction		Name and location of Court		inclu	osition uding rceration	
Offense			Date of conviction		Name and location of Court		inclu	osition uding rceration	
Offense			Date of conviction		Name and location of Court		inclu	osition uding rceration	
Offense			Date of conviction		Name and location of Court		inclu	osition Iding rceration	
Applica	ınt Attestat	ion:							
By my si	gnature be	low, I declare	and affirm t	hat I have rea	d and fully unders	tand that:			
candida	cy for the p	osition for wh	hich I have re		is form shall be suf ditional offer of en nired.				
Signatu	re						Date		
	E USE ONL	<u>.Y</u> ector of Hum	an Resource:	s					
Name									
Signatu	re						Date		

CUNY EMPLOYMENT APPLICATION - PART TWO Rev. 9-22-15

Page 3 of 3

BOROUGH OF MANHATTAN COMMUNITY COLLEGE

The City of New York
Department of Personnel

AGENCY SHOP FEE AGREEMENT

This form must be completed by all employees except those in the managerial Pay Plan, Original Jurisdiction titles, and those employees specifically excluded from collective bargaining by decisions of the Office of Collective Bargaining.

Notice to Employee:

Under an act passes by the New York State Legislature and by agreement between the City and the municipal employee unions, employees in titles which are represented in collective bargaining but who are not union members are subject to a deduction from their salary in an amount equal to the amount payable by a union member.

Employee Affirmation:

I have been informed that I have the right to join or refrain from joining the union certified for my title. I understand that if I refrain from joining I will be subject to an Agency Shop fee deduction, which shall be an amount equivalent to the amount of dues payable by a union member.

Employee Signature	Date	

TO BE FILLED OUT BY AGENCY

NOTICE TO UNION:	
Please be advised of the appointment	or change in status of the employee as indicated below:
Fundame Name	
Employee Name:	
Title:	Social Security Number Check Digit
Job Sequence Number (JSN):	Check one: Assigned [] Automatically [] Manually (List plan assigned)
Payroll No.:	_ Title Code No.:
Agency Address:	Agency Clerk:
Phone No.:	
Name of Union:	
To the Union: If the deduction plan was assigned	d incorrectly, submit correction to the Organizational dues Unit Office of navroll Administra

*FORWARD TO THE APPROPRIATE UNION
**MAINTAIN A COY IN EMPLOYEE'S PERSONNEL FILE



Borough of Manhattan Community College The City University of New York www.bmcc.cuny.edu 199 Chambers Street New York, NY 10007-1097 tel. 212-220-8300 fax 212-220-2364

Tax Certification for Foreign Nationals

(Excluding Applicants with Permanent Resident Status)

The City University of New York has currently implemented the **GLACIER** online tax compliance system and all Foreign Nationals will be required to register through it, in order to ensure that the appropriate taxation is deducted from you wages. To complete your individual tax record, you will need to obtain instructions and a password from the Office of Human Resources. **Please contact the individuals listed below at your earliest convenience, but no later than 10 days after your employment begins.**

Gloria Chao Phone Number: (212) 220-8300 E-Mail Address: gchao@bmcc.cuny.edu

Please note that unless your record is completed in **GLACIER**, and copies of the supported documents are submitted, the Payroll Office had been instructed to withhold taxes at the maximum rate of withholding until your record in **GLACIER** has been completed. Furthermore, any taxes withheld will not be refunded by the Payroll office under circumstance.

I have been notified of my requirements to complete certain information in GLACIER. I

understand that I must go to the Office of Human Resources to obtain access and instructions for GLACIER.						
Employee Name (Print)						
Employee Signature	Date					
E-mail Address (CUNY e-mail preferred)	Employee Phone Number					
Form I-9 Certifier Signature	Date					



Health Benefits Application

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

Health Benefits Program

40 Rector Street - 3rd Floor New York, NY 10006 (212) 513-0470 TTY/TDD: (212) 306-7753 www.nyc.gov/olr

Applicant MU	JST check one:				this box	if you wer	e previo	usly retired)						
REASON(S) E	FOR SUBMISSION	1			ne date if a	nnronriate)							
	nrollment		d Optional Benefits	B.				Optional/Benefit	C. Ch	ange of:				
	atement		incel Benefits (check of		Based on		iii aiia/oi k	optional/benefit	C. OI	Spouse/D	omestic	Partner	Γ Α	d Dron
Retirem			Waive Benefits	0.107	Trans	fer Period				Effective				
	ity Retirement	<u> </u>	Buy-Out Waiver Pr	rogram			Into/Out of	Health Plan Area		Depender	_			
	nt Disability Retirement		(employees only - co	-		tive Date:				Effective				- '
			sections D, e, F &	i only)		ee Once-in-A				Change o				
	ptional Benefits				Othe]				
Other:_					Otrie									
Last Name:	EE/RETIREE INFO	RMATION	V	First Name:				M.I.:	Social S	ecurity Nu	ımber:			
Home Address:												-	Apt. No	:
City :				Ctata	Zin Codo:		Country (if autoida tha II C	٠ ١.					
City:				State:	Zip Code:		Country (if outside the U.S	o.):					
Date of Birth:	Sex:	Hor	me - Telephone Nun	nber:	v	/ork - Teleph	none Num	ber:	Mol	bile - Telep	ohone N	Number:		
1	/ <u>M</u> M)	-		()		-	()		-		
	e Married Divor	L.E.L.	ate of Event (mm/dd/	yy) Agency i	in which em	ployed or re	tired from	: Un	ion or We	lfare Fund				
Name of current (City Health Plan:	I		Med	dicare Clain	Number:	If Medi	care Part A - Effec	tive Date:	1	/			attach
				T///0.00	EOTION D	FT/DEF0.0		care Part B - Effec	ctive Date:	/	/			copy of card
Retirement Syste	em:		Year	rs Credited Se		ity Start Dat		Retirement I	Date:	Pen	sion Nu	ımber:		
						1	1	1	1					
	DOMESTIC PARTI	NER INFO	DRMATION											
Last Name:				First Name:				M.I.: Social S	Security N	umber:		Date	of Birth	1:
le enquee/domest	tic partner: Employe	d П Retir	red Not Employe	d			Is spous	e/domestic partne	er to be co	vered by	emplov	ee/retire	e's He	alth Plan?
City Agency Na		и Циси	La Divot Employe	·u	Non-Ci	. Dolotod	,	City coverage is I						
	mestic partner have No	on-City aro	up health plan?	Med	dicare Clain		_	care Part A - Effec		/ Lea,	<u>" П</u>	10		
Docs spouse/don	nestic partiter have in	—	ap ricaitir piarr:	IVICC	alcaic Olaiii	i i vaii ibci.	ii weak	cale Fall A - Ellec	live Date.	1	/			a tt ach
	□Voo	No					<u> </u>	D D	dia Data	,	,			copy of
	Yes	No						care Part B - Effec		1	1			copy of card
	NFORMATION (Atta	ach a sec		sary; depen	dent may	not be cov				/ ns.)	/			copy of card
List all eligible de (CUNY ADJUNC	NFORMATION (Atta ependents to be covered T EMPLOYEES: City (ach a seco	Health Plan.				ered und	er two NYC He	alth Plar	ns.)	Char	ok if App		copy of card
List all eligible de (CUNY ADJUNCT cost for Family co	NFORMATION (Atta ependents to be covered T EMPLOYEES: City of poverage.)	ach a seco	Health Plan. for Individual cover		ontact your	Benefits Off	ered und	er two NYC He	ealth Plar	full-tir	ne p	ck if App	licable	drop
List all eligible de (CUNY ADJUNCT cost for Family co La	NFORMATION (Atta ependents to be covered T EMPLOYEES: City in poverage.)	ach a seco	Health Plan.			Benefits Off	ered und	er two NYC He	alth Plar		ne p		licable	card
List all eligible de (CUNY ADJUNCT cost for Family co La	NFORMATION (Atta ependents to be covered T EMPLOYEES: City of poverage.)	ach a seco	Health Plan. for Individual cover		ontact your	Benefits Off	ered und	er two NYC He	ealth Plar	full-tir	ne p	ermanei	licable	drop
List all eligible de (CUNY ADJUNCT cost for Family co La	NFORMATION (Atta ependents to be covered T EMPLOYEES: City in poverage.)	ach a seco	Health Plan. for Individual cover		ontact your	Benefits Off	ered und	er two NYC He	ealth Plar	full-tir	ne p	ermanei	licable	drop
List all eligible de (CUNY ADJUNCT cost for Family co La Spouse/D	PROPRIED (Attachment of the pendents to be covered to the EMPLOYEES: City in poverage.) The pendents to be covered to the pendents to the pendent	ach a seco	Health Plan. for Individual cover		ontact your	Benefits Off	ered und	er two NYC He	ealth Plar	full-tir	ne p	ermanei	licable	drop
List all eligible de (CUNY ADJUNCT cost for Family co La Spouse/D	NFORMATION (Atta ppendents to be covered T EMPLOYEES: City to poverage.) ast Name:	ach a seco	Health Plan. for Individual cover		ontact your	Benefits Off	ered und	er two NYC He	ealth Plar	full-tir	ne p	ermanei	licable	drop
List all eligible de (CUNY ADJUNCT cost for Family co La Spouse/D	NFORMATION (Atta ependents to be covered T EMPLOYEES: City in overage.) ast Name:	ach a seco	Health Plan. for Individual cover		ontact your	Benefits Off	ered und	er two NYC He	ealth Plar	full-tir	ne p	ermanei	licable	drop
List all eligible de (CUNY ADJUNCT cost for Family co La Spouse/D	NFORMATION (Atta ppendents to be covere T EMPLOYEES: City to overage.) ast Name: Domestic Partner tependent tependent tependent	ach a seco	Health Plan. for Individual cover First Name:		ontact your	Benefits Off	ered und	er two NYC He	ealth Plar	full-tir	ne p	ermanei	licable	drop
List all eligible de (CUNY ADJUNCT cost for Family co	PLAN REQUESTE	ach a seco	Health Plan. for Individual cover First Name:		ontact your	Benefits Off	ered und	er two NYC He	ealth Plar	full-tir	ne p	ermanei	licable	drop
List all eligible de (CUNY ADJUNCT cost for Family co	PLAN REQUESTE	ach a second by your livates apply	Health Plan. for Individual cover. First Name:	age ONLY. C	Date of Bil	Benefits Off	ered und	er two NYC Herritan about an exercise surity Number:	dditional Sex:	full-tir	ne pnt	ermaner disable	licable	drop
List all eligible de (CUNY ADJUNCT cost for Family co La Spouse/D D G. HEALTH F HEALTH PLAN N Optional Benefits	NFORMATION (Atta ppendents to be covere T EMPLOYEES: City is overage.) ast Name: Domestic Partner dependent dependent dependent dependent dependent DAME IN FULL:	ach a second by your largest apply D (Please	Health Plan. for Individual cover. First Name: print clearly)	age ONLY. C	ontact your Date of Bir / / / / / / / / ked, it will b	Benefits Off	ered und	er two NYC Herrican about an exercise Number:	ealth Plandditional Sex:	full-tistude	ne pnt P	ermanei disablee	licable http	drop
G. HEALTH FLAN NOptional Benefits H. TO PARTI	NFORMATION (Attapendents to be covered to be	D (Please	Health Plan. for Individual cover. First Name: print clearly) al benefits rider. If ne	age ONLY. C	ontact your Date of Bir / / / / / / / / / / ked, it will the	Benefits Off th:	ered und fice for info Social Sec that you o	er two NYC Heromation about an eurity Number: do not want optio	dditional Sex:	full-tirstudes	ne pnt	ermanei disable	licable ntly d	drop
G. HEALTH F HEALTH PLAN N Optional Benefits H. TO PARTI I certify that the a I understand that	NFORMATION (Attapendents to be covered to be	D (Please " for option EALTH BI prect and I enefits will be	Health Plan. for Individual cover. First Name: print clearly) all benefits rider. If n ENEFITS PROGE authorize the City to be coordinated with	no box is chec RAM PLEA o deduct from those availab	Date of Bir	e presumed AND DAT pension the Medicare or	ered und fice for info Social Sec that you o E BELO amount re any other	er two NYC Heromation about an eurity Number: do not want optio W (Participant equired, if any, this source.	salth Plandditional Sex: nal benefit must signough the	full-tirstude:	ne phit Phit Section h Benefit	o n H or I	licable ntly d c	drop
G. HEALTH F HEALTH PLAN N Optional Benefits H. TO PARTI I certify that the a I understand that Furthermore, I ag	NFORMATION (Attapendents to be covered to be	D (Please " for option EALTH Bi Denefits will the alth plan	Health Plan. for Individual cover. First Name: print clearly) all benefits rider. If n ENEFITS PROGE authorize the City to be coordinated with deductions, if any, v	no box is chec RAM PLEA o deduct from those availab will be made o	Date of Bin / / / / / / / / / / / / / / / / / / /	e presumed AND DAT pension the Medicare or basis pursu.	that you of EBELO amount reany other ant to the	er two NYC He primation about accurity Number: do not want option W (Participant equired, if any, the source. Internal Revenue	nal benefit must signough the	ts.) Yes n either S City Healt	Section h Benefitstand th	o o o o o o o o o o o o o o	licable ntly d c	drop
G. HEALTH F HEALTH PLAN N Optional Benefits T O PARTI I certify that the a I understand that Furthermore, I agdecline this benefits benef	NFORMATION (Attapendents to be covered to be	D (Please " for option EALTH BI Direct and I enefits will the ealth plan dical Spend	Health Plan. for Individual cover. First Name: print clearly) all benefits rider. If n ENEFITS PROGE authorize the City to be coordinated with deductions, if any, voling Conversion Form	no box is chec RAM PLEA o deduct from those availab will be made o m, both of whi	Date of Bin / / / / / / / / / / / / / / / / / / /	e presumed AND DAT pension the Medicare or basis pursu- inable at my	ered und fice for info Social Sec that you of EBELO amount reany other any other ant to the	er two NYC Heromation about an eurity Number: do not want option W (Participant equired, if any, the source. Internal Revenue (fice. (Section 12)	nal benefit must signough the e Code 12:5 does not	ts.) Yes n either S City Healt	Section h Benefitstand th	o o o o o o o o o o o o o o	licable ntly d c	drop
G. HEALTH F HEALTH PLAN N Optional Benefits I certify that the a I understand that Furthermore, I agdecline this benefits benefit	NFORMATION (Attapendents to be covered to be	D (Please " for option EALTH BI Direct and I enefits will the ealth plan dical Spend	Health Plan. for Individual cover. First Name: print clearly) all benefits rider. If n ENEFITS PROGE authorize the City to be coordinated with deductions, if any, voling Conversion Form	no box is chec RAM PLEA o deduct from those availab will be made o m, both of whi	Date of Bin / / / / / / / / / / / / / / / / / / /	e presumed AND DAT pension the Medicare or basis pursu- inable at my	ered und fice for info Social Sec that you of EBELO amount reany other any other ant to the	er two NYC Heromation about an eurity Number: do not want option W (Participant equired, if any, the source. Internal Revenue (fice. (Section 12)	nal benefit must signough the e Code 12:5 does not	ts.) Yes n either S City Healt	Section h Benefitstand th	o o o o o o o o o o o o o o	licable ntly d c	drop
G. HEALTH F HEALTH PLAN N Optional Benefits I certify that the a I understand that Furthermore, I ag decline this benefit in the center of the	NFORMATION (Attapendents to be covered to be	D (Please " for option EALTH BI Denefits will the alth plan dical Spend ox in Section	Health Plan. for Individual cover. for Individual cover. First Name: print clearly) all benefits rider. If n ENEFITS PROGE authorize the City to be coordinated with deductions, if any, voling Conversion Forton A, I am choosing	no box is chec RAM PLEA o deduct from those availab will be made o m, both of whi not to particip	Date of Bin / / / / / / / / / / / / / / / / / / /	e presumed AND DAT pension the Medicare or basis pursu- inable at my	ered und fice for info Social Sec that you of E BELO amount reany other any other ant to the payroll of enefits Pr	er two NYC Hermation about an eurity Number: do not want option W (Participant equired, if any, the source. Internal Revenue effice. (Section 12 ogram at this tim	nal benefit must signough the e Code 12:5 does not e.	ts.) Yes n either S City Health tapply to a	Section h Benefit stand thretirees	o H or I fits Prog	licable ntly c	drop coverage
G. HEALTH F HEALTH PLAN N Optional Benefits H. TO PARTI I certify that the a I understand that Furthermore, I ag decline this benefit benefits I have checked Employee/Retired I. TO PARTI I wish to participations.	NFORMATION (Attapendents to be covered to be	D (Please " for option EALTH BI prect and I enefits will the ealth plan lical Spend ox in Section EALTH BI efits Buy-Out	Health Plan. for Individual cover. for Individual cover. First Name: Print Clearly) First Name: Print Clearly) First Name: First N	no box is chec RAM PLEA o deduct from those availab will be made o m, both of whi not to particip UT WAIVER	Date of Bin / / / / / / / / / / / / / / / / / / /	e presumed AND DAT pension the Medicare or basis pursu- inable at my city Health B	that you of EBELO amount reany other ant to the payroll of enefits Pr	er two NYC Hermation about an exurity Number: do not want option W (Participant equired, if any, this source. Internal Revenue effice. (Section 12 ogram at this tim	nal benefit must signough the e Code 12:5 does not e. Participar Buy-Out W	ts.) Yes n either S City Health tapply to a	Section h Benefit stand thretirees ate:	on H or I fits Prograt I hav	ram.	drop coverage tition to
G. HEALTH F HEALTH PLAN N Optional Benefits H. TO PARTI I certify that the a I understand that Furthermore, I ag decline this benefit benefits I have checked Employee/Retired I. TO PARTI I wish to participations.	NFORMATION (Attapendents to be covered to be	D (Please " for option EALTH BI prect and I enefits will the ealth plan lical Spend ox in Section EALTH BI efits Buy-Out	Health Plan. for Individual cover. for Individual cover. First Name: Print Clearly) First Name: Print Clearly) First Name: First N	no box is chec RAM PLEA o deduct from those availab will be made o m, both of whi not to particip UT WAIVER	Date of Bin / / / / / / / / / / / / / / / / / / /	e presumed AND DAT pension the Medicare or basis pursu- inable at my city Health B	that you of EBELO amount reany other ant to the payroll of enefits Pr	er two NYC Hermation about an exurity Number: do not want option W (Participant equired, if any, this source. Internal Revenue effice. (Section 12 ogram at this tim	nal benefit must signough the e Code 12:5 does not e. Participar Buy-Out W	ts.) Yes n either S City Health tapply to a	Section h Benefit stand thretirees ate:	on H or I fits Prograt I hav	ram.	drop coverage tition to
G. HEALTH F HEALTH PLAN N Optional Benefits I certify that the a I understand that Furthermore, I ag decline this benefit I have checked Employee/Retired I. TO PARTI I wish to participe Medical Spending	PLAN REQUESTE NAME IN FULL: S? (Check "Yes" or "No ICIPATE IN THE HI above information is co to the Waive Benefits B se Signature: ICIPATE IN THE HI above information is co to the Waive Benefits B se Signature: ICIPATE IN THE HI above information is co to the Waive Benefits B se Signature: ICIPATE IN THE HI above information is co to the Waive Benefits B se Signature: ICIPATE IN THE HI above in the Health Benefits B se Signature:	D (Please " for option EALTH BI prect and I enefits will the ealth plan lical Spend ox in Section EALTH BI efits Buy-Out	Health Plan. for Individual cover. for Individual cover. First Name: Print Clearly) First Name: Print Clearly) First Name: First N	no box is chec RAM PLEA o deduct from those availab will be made o m, both of whi not to particip UT WAIVER	Date of Bin / / / / / / / / / / / / / / / / / / /	e presumed AND DAT pension the Medicare or basis pursu- inable at my city Health B	that you of EBELO amount reany other ant to the payroll of enefits Pr	er two NYC Hermation about an exurity Number: do not want option W (Participant equired, if any, this source. Internal Revenue effice. (Section 12 ogram at this tim	nal benefit must signough the e Code 12:5 does not e. Participar Buy-Out W	ts.) Yes n either S City Healt tapply to b	Section h Benefit stand thretirees ate:	on H or I fits Prograt I hav	ram.	drop coverage tition to
G. HEALTH F HEALTH PLAN N Optional Benefits I certify that the a I understand that Furthermore, I ag decline this benefit limites benefit limi	NFORMATION (Attappendents to be covered to b	D (Please " for option EALTH BI prect and I enefits will be the alth plan dical Spendo ox in Section of I attest the second I attest I attest the second I attest I attest I attest I attest I attest I attes	Health Plan. for Individual cover. for Individual cover. First Name: Print Clearly) Final benefits rider. If note that the coordinated with deductions, if any, with deductions, if any, with the coordinated	age ONLY. Consider the constant of the constan	Date of Bin / / / / / / / / / / / / / / /	e presumed AND DAT pension the Medicare or basis pursu- inable at my city Health B	that you of EBELO amount reany other ant to the payroll of enefits Pr	er two NYC Hermation about an exurity Number: do not want option W (Participant equired, if any, this source. Internal Revenue effice. (Section 12 ogram at this tim	nal benefit must signough the e Code 12:5 does not e. Participar Buy-Out W	ts.) Yes n either S City Healt tapply to b	Section h Beneficiate: ign eitligram broyees a	on H or I fits Prograt I hav	ram.	drop coverage tition to
G. HEALTH F HEALTH PLAN N Optional Benefits I certify that the a I understand that Furthermore, I ag decline this benefit limites benefit limi	NFORMATION (Attappendents to be covered to b	D (Please " for option EALTH BI prect and I enefits will be ealth plan dical Spendo ox in Section EALTH BI prect and I attest the second I attes	Health Plan. for Individual cover. for Individual cover. First Name: Print Clearly) The print clearly First Name: Firs	age ONLY. Consider the second of the second	Date of Bin / / / / / / / / / / / / / / /	e presumed AND DAT Dension the Medicare or basis pursuinable at my City Health B AM SIGN Spending Co (Retirees, L	that you of EBELO amount reany other and to the properties Properties of Duffer and that define of Duffer and that define of Duffer and that define and that d	curity Number:	nal benefit must sign cough the coole 12: 5 does not e. Participar Buy-Out W CUNY Adj	ts.) Yes n either S City Healtl 5. I unders t apply to a aiver Progunct empl	Section h Benefit stand the retirees ate:	on H or I fits Prograt I hav	pram. e an operation Heand correligible.	drop coverage drop coverage drop coverage drop coverage drop coverage
G. HEALTH F G. HEALTH F HEALTH PLAN N Optional Benefits H. TO PARTI I certify that the a I understand that Furthermore, I ag decline this benefit I have checked Employee/Retiree I. TO PARTI I wish to participe Medical Spendin Employee Signat J. FOR COM I certify that the a procedures. I ce	NFORMATION (Attappendents to be covered to poverage.) ast Name: Domestic Partner Domestic Partner Dependent Dependen	D (Please " for option EALTH BI orrect and I enefits will be east in Section EALTH BI orrect and I attest the second of I attest the se	Health Plan. for Individual cover. for Individual cover. First Name: Pirst Name:	no box is chec RAM PLEA o deduct from those availab will be made o m, both of whi not to particip UT WAIVER I have read th fications for th	Date of Bin / / / / / / / / / / / / / / /	e presumed AND DAT Dension the Medicare or basis pursuinable at my City Health B AM SIGN Spending Co (Retirees, L	that you of EBELO amount reany other and to the properties Properties of Duffer and that define of Duffer and that define of Duffer and that define and that d	curity Number:	nal benefit must sign cough the coole 12: 5 does not e. Participar Buy-Out W CUNY Adj	ts.) Yes n either S City Healtl 5. I unders t apply to a aiver Progunct empl	Section h Benefit stand the retirees ate:	on H or I fits Prograt I hav	pram. e an operation Heand correligible.	drop coverage drop coverage drop coverage drop coverage drop coverage
G. HEALTH F HEALTH PLAN N Optional Benefits I certify that the a I understand that Furthermore, I ag decline this benefit I have checked Employee/Retired I. TO PARTI I wish to participa Medical Spendin Employee Signat J. FOR COM I certify that the a procedures. I ce and I attest that	NFORMATION (Attappendents to be covered to b	D (Please " for option EALTH BI orrect and I enefits will be east in Section EALTH BI orrect and I attest the second of I attest the se	Health Plan. for Individual cover. for Individual cover. First Name: Pirst Name:	no box is chec RAM PLEA o deduct from those availab will be made o m, both of whi not to particip UT WAIVER I have read th fications for th	Date of Bin / / / / / / / / / / / / / / /	e presumed AND DAT Dension the Medicare or basis pursuinable at my City Health B AM SIGN Spending Co (Retirees, L	that you of EBELO amount reany other and to the properties Properties of Duffer and that define of Duffer and that define of Duffer and that define and that d	curity Number:	nal benefit must sign cough the cook 12:5 does not e. Participal Buy-Out W CUNY Adj	ts.) Yes n either S City Healtl 5. I unders t apply to a aiver Progunct empl	Section h Benefit ate: ign eitligram broyees a ate: errified in all Spen	on H or I fits Prograt I hav	pram. e an operation Heand correligible.	drop coverage drop coverage drop coverage drop coverage drop coverage
G. HEALTH F G. HEALTH F HEALTH PLAN N Optional Benefits H. TO PARTI I certify that the a I understand that Furthermore, I ag decline this benefit I have checked Employee/Retiree I. TO PARTI I wish to participe Medical Spendin Employee Signat J. FOR COM I certify that the a procedures. I ce	NFORMATION (Attappendents to be covered to b	D (Please " for option EALTH BI orrect and I enefits will be east in Section EALTH BI orrect and I attest the second of I attest the se	Health Plan. for Individual cover. for Individual cover. First Name: Pirst Name:	no box is chec RAM PLEA o deduct from those availab will be made o m, both of whi not to particip UT WAIVER I have read th fications for th	Date of Bin / / / / / / / / / / / / / / /	e presumed AND DAT Dension the Medicare or basis pursuinable at my City Health B AM SIGN Spending Co (Retirees, L	that you of EBELO amount reany other ant to the properties Properties of Duffer and I have and I have	curity Number:	nal benefit must sign cough the cook 12:5 does not e. Participal Buy-Out W CUNY Adj	ts.) Yes n either S City Healt bit apply to a as been very the Medicity to	Section h Benefit ate: ign eitligram broyees a ate: errified in all Spen	on H or I fits Prograt I hav	pram. e an operation Head coreligible.	drop coverage drop coverage drop coverage drop coverage drop coverage
G. HEALTH F HEALTH PLAN N Optional Benefits I certify that the a I understand that Furthermore, I ag decline this benefit I have checked Employee/Retired I. TO PARTI I wish to participa Medical Spendin Employee Signat J. FOR COM I certify that the a procedures. I ce and I attest that	NFORMATION (Attapendents to be covered to be	D (Please " for option EALTH BI orrect and I enefits will be east in Section EALTH BI orrect and I attest the second of I attest the se	Health Plan. for Individual cover. for Individual cover. First Name: Pirst Name:	no box is chece RAM PLEA o deduct from those availab will be made of m, both of whi not to particip I have read the fications for the OFFICE ONI City Health Be the Benefits Bu am.	Date of Bin / / / / / / / / / / / / / / /	e presumed AND DAT pension the Medicare or basis pursu- inable at my city Health B AM SIGN Spending Co (Retirees, L	that you or EBELO amount reany other ant to the repayroll of the payroll of the p	curity Number:	nal benefit must sign cough the cocondition of the	ts.) Yes n either S City Healt bit apply to a as been very the Medicity to	Section h Benefit stand the retirees ate: ate: erified in: cal Speciment in the stand in the retirees ate: ate	on H or I fits Prograt I hav	ram. e an operation Hand coreligible.	drop coverage intion to / or I) inpleted a) / with HBP on Form

Full-Time

Part-Time

Civil Servant

Provisional

 ${\bf q} \ {\sf Weekly}$

q Bi-Weekly

 ${f q}$ Monthly

q Semi-Monthly

Death Benefit Beneficiary Designation Card

Name of Em	ployee							
(Last)			(First)		(Middle Initi	al)		
Social Securi	ty Number		Male		Date of Birt	:h:		
				_	Mo.	Day	YR.	
_			Female					
Name of Col	lege:							
Date Employ	/ed:							
Primary Ben	eficiary Nam	ne:		Telephone Number				
				relation to me:				
Primary Ben	eficiary Add	ress:						
Contingent I	Beneficiary N	lame:		Telephone Number:				
					relation to	me:		
Contingent I	Beneficiary A	Address:						
Date Signed			Signature of E	mployee				
Mo.	Day	YR.						

Order of Payment and Division of Benefits. Unless otherwise provided:

- (a) Payment at my death is to be made to a primary beneficiary if he/she is then living
- (b) Payment at my death is to be made to a contingent beneficiary if he/she is then living and there is no primary beneficiary then living.
- (c) If all beneficiaries predecease me, the benefits will be payable to my estate.

EMPLOYEE Health Plan Rates as of July 1, 2015

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

(All rates are subject to change)

			kly	Bi-W	eekly	Semi-Monthly		
		Individual	Family	Individual	Family	Individual	Family	
Aetna EPO	Basic Plan	\$36.79	\$188.29	\$73.57	\$376.57	\$80.14	\$410.20	
Optional Rider Pre	scription Drugs	53.77	136.21	107.55	272.43	117.15	296.75	
	TOTAL	\$90.56	\$324.50	\$181.12	\$649.00	\$197.29	\$706.95	
CIGNA HealthCare	Basic Plan	\$139.39	\$379.29	\$278.79	\$758.58	\$303.68	\$826.31	
Optional Rider Pre	scription Drugs	51.79	155.04	103.57	310.09	112.82	337.78	
	TOTAL	\$191.18	\$534.33	\$382.36	\$1,068.66	\$416.50	\$1,164.08	
DC37 Med-Team (DC 37 members only)	Basic Plan	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
(No Rider Available)	TOTAL	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Empire EPO	Basic Plan	\$128.75	\$328.88	\$257.49	\$657.77	\$280.49	\$716.50	
Optional Rider Pre	scription Drugs	36.06	88.40	72.12	176.79	78.56	192.58	
	TOTAL	\$164.81	\$417.28	\$329.61	\$834.56	\$359.04	\$909.07	
Empire HMO	Basic Plan	\$49.45	\$149.33	\$98.90	\$298.66	\$107.73	\$325.33	
Optional Rider Pre	scription Drugs	36.06	88.40	72.12	176.79	78.56	192.58	
	TOTAL	\$85.51	\$237.72	\$171.02	\$475.45	\$186.29	\$517.90	
GHI-CBP/Empire BlueCross BlueSl	nield							
	Basic Plan	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Optional Rider Pre	escription Drugs	27.54	49.34	55.08	98.69	60.00	107.50	
Enhanced Major M	edical Coverage	1.47	3.73	2.95	7.46	3.21	8.13	
	TOTAL	\$29.01	\$53.07	\$58.03	\$106.15	\$63.21	\$115.63	
GHI НМО	Basic Plan	\$24.73	\$76.87	\$49.45	\$153.73	\$53.87	\$167.46	
Optional Rider Pre	scription Drugs	44.96	114.64	89.93	229.27	97.96	249.75	
	TOTAL	\$69.69	\$191.50	\$139.38	\$383.01	\$151.83	\$417.21	
HIP Prime HMO	Basic Plan	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Optional Rider Pre	scription Drugs	33.98	83.24	67.95	166.49	74.02	181.35	
Durable Medicate Equipment & Priva	te Duty Nursing		3.23	2.63	6.45		7.03	
	TOTAL	\$35.29	\$86.47	\$70.59	\$172.94	\$76.89	\$188.38	
HIP Prime POS	Basic Plan	\$151.37	\$370.92	\$302.75	\$741.83	\$329.78	\$808.07	
Optional Rider Pre	scription Drugs	121.44	295.85	242.88	591.69	264.57	644.52	
	TOTAL	\$272.82	\$666.76	\$545.63	\$1,333.53	\$594.35	\$1,452.59	
Metroplus (HHC Employees Only)	Basic Plan	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Optional Rider Pre	scription Drugs	35.15	80.74	70.30	161.47		175.89	
	TOTAL	\$35.15	\$80.74	\$70.30	\$161.47	\$76.58	\$175.89	
Vytra	Basic Plan	•	\$71.64	\$35.05	\$143.28	\$38.18	\$156.08	
Optional Rider Pre	scription Drugs		101.47		202.94		221.06	
	TOTAL	\$56.54	\$173.11	\$113.08	\$346.22	\$123.18	\$377.14	



Enrollment Form PSC-CUNY Welfare Fund

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

[PSC-CUN	Y WF Office Use Only]
Data _	
Rx _	
ASO _	
Dental	
Stipeno	d □Waived/Buy-out
	d □Waived/Buy-out

Authorization

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 A		-	2011CU.		
Enrollee		NY State ID#	N		_
Last Name	First Name				_
Social Security Number	Job Title				_
Home Address					_
City	State	_	Zip Code		_
Primary Contact # ()	Primary Email				_
Date of Birth /	Sex	Marital Status		Domestic Partner	
CUNY Campus	Health Insurance	1]	Basic Rider	
Welfare Fund Dental Option	Effective Date of	Hire			
Guardian	Earliest CUNY Hire	Date			
DeltaCare USA (Attach DeltaCare Form)	Previous College (if	applicable)			
I hereby certify that all information I have provided on this Enrollment	Form is true and accura	te.			
Member Signature			Date		_
[College HR Office Use Only] Chec	<u>k here if this enrollee i</u>	s classified mana	<u>gerial</u>		
The individual named herein is eligible for coverage effective					-
Signature	Position		_	/ / Date	-
[PSC-CUNY Welfare Fund Use Only]					

Status

The City University of New York Information regarding Pension System Membership

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

All Full-time instructional staff is eligible for membership in either the Optional Retirement Program (ORP), which refers to membership in TIAA/CR\$EF and the Alternate Funding Vehicles, or the new York City Teachers' 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 a mandatory for all **full-time** instructional staff. Substitutes can join the ORP only (unless they are Transferred Contributors of another public pension).

New instructional staffs 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 Human Resources 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 Human Resources regarding any questions I may have had concerning my pension program options and rights.

Name	Signature	
HR Verification		

The information 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.

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 of reclassified to an eligible Instructions 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), must enroll on line. Those failing to complete the election process within the statutory time frame noted above are forced into membership with the NYTRS by law (Civil Service Managers into the NYCERS).

Section 1: Personal Information
Name: Social Security Number:
Address:
College: Borough of Manhattan Community College Job Title: Pension 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 only one)
1. The Optional Retirement Program (ORP). I understand that I have to complete the application for TIAA/CREF process on line;
2. The New York Teachers' Retirement System* (Instructional Staff members only, unless already a member of the NYCTRS through a former position on public service);
3. ☐ The New York City Employees' Retirement System* (Classified Managers only, unless already a member of NYCERS through a former position on public service);
4. ☐ The Board of Education 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
*Those participating as Transferred Contributors please check here.

The City University of New York

Information regarding Pension System Membership

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

All Full-time instructional staff is eligible for membership in either the Optional Retirement Program (ORP), which refers to membership in TIAA/CR\$EF and the Alternate Funding Vehicles, or the new York City Teachers' 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 a mandatory for all **full-time** instructional staff. Substitutes can join the ORP only (unless they are Transferred Contributors of another public pension).

New instructional staffs 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 Human Resources 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 Human Resources regarding any questions I may have had concerning my pension program options and rights.

Name	Signature	
HR Verification	<u> </u>	

The information 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.



CHOOSING A PENSION PLAN: A GUIDE FOR NEW MEMBERS

New York State law mandates participation in a retirement system for full time members of the instructional staff. New staff members have 30 days from the effective date of their appointment to choose a retirement program, and the choice is irrevocable. If no choice is filed within 30 days, the law mandates that the member be assigned to the New York City Teacher's Retirement System (TRS).

Full-time instructional staff members must choose between the New York City Teachers' Retirement System (TRS) and the Optional Retirement Program (ORP). Those who elect the Optional Retirement Program must choose investment options through either Teachers Insurance and Annuity Association-College Retirement Equities Fund (TIAA-CREF) or through the alternate funding vehicles offered by Guardian or MetLife. More information may be obtained from your college HR Office.

Adjuncts employed by CUNY are only eligible for membership in TRS and may join at their option. Additional information on choosing a pension plan is available from Jared Herst, PSC Coordinator of Pension and Welfare Benefits at (212) 354-1252 or jherst@pscmail.org.

CUNY's Pension Options

System	New York City Teachers' Retirement System (TRS)	Optional Retirement Program			
Type of Basic Retirement Plan	Defined benefit plan: Benefits are based on age, Final Average Salary* (FAS) and years of employment. *Final Average Salary (FAS): Average of your highest five consecutive annual salaries with certain limitations.	contributed by the employer and employee and earnings of the employee's choice of investments. Average of your highest five			
Vesting	After ten years of total credited service	After 366 days of continuous full-time employment. (Immediate if employee has a pre-existing, vested TIAA-CREF Retirement Annuity (RA) or Group Retirement Annuity (GRA) Contract.)			
Retirement Age	Age 63: Immediate, unreduced benefits. Age 55 to 62: Immediate, reduced benefits at 6.5% per year between those ages.	No age limitation: A member may choose to retire and begin annuity income after vesting without a reduction in benefits.			
NYC Retirement Health Benefits	Full-time CUNY employees with 10 years of credited service, age 55 old and receiving a pension. Health insurance premiums are deducted from employees' basic pension payouts in retirement.	A member with at least 15 years of pensionable, continuous, full-time CUNY service and who is at least age 62. Note: As of 9/1/05, if you are a health-benefits-eligible retiree, you are required to maintain \$50,000 in reserve, with TIAA-CREF, in order to pay for retiree health insurance premiums. Additional reserve amounts may be required depending on the health plan you select or to cover future insurance rate increases.			
Retirement Allowances	For Members who join TRS after 3/31/2012: Less than 20 years of service: 1.67% x FAS x years of service. 20 years of service: 1.75% x FAS x Years of service (for first 20 years) + 2% FAS for each year of total service credit above 20.	Retirement benefits are based on total accumulations, age at retirement, and the income options selected.			
Contribution Rates	Employee pays 3% of regular compensation on a federally tax-deferred basis through 3/31/2013. Thereafter, the contribution rate varies for the remainder of service, dependent upon an employee's salary:\$45,000 or less 3.00%More than \$45,000 to \$55,000: 3.50%More than \$55,000 to \$75,000 4.50%More than \$75,000 to \$100,000 5.75%More than \$100,000 6.00% Employer contributes a lump-sum annually to TRS	Employee pays 3% of regular compensation on a federally tax-deferred basis through 3/31/2013. Thereafter, the contribution rate varies for the remainder of service, dependent upon an employee's salary:\$45,000 or lessMore than \$45,000 to \$55,000:More than \$55,000 to \$75,000More than \$75,000 to \$100,000More than \$100,000			

CHOOSING A PENSION PLAN: A GUIDE FOR NEW MEMBERS (continued)

System	New York City Teachers' Retirement System (TRS)	Optional Retirement Program
Tax-Deferred	Voluntary TRS TDA 403(b) is available for members of	Voluntary TIAA-CREF TDA 403 (b) is available
Annuity (TDA)	TRS basic retirement plan.	
	Note that other tax-deferred retirement investment	options are also available. For more information, contact
	your campus HR benefits officer o	r reach out to Jared Herst at PSC-CUNY.
Retirement	Ordinary Disability benefits: 10 or more years of	A member who has been certified disabled and retires
Disability	service credit required.	may receive annuity payments and city-provided health
Benefits	Accident Disability Benefits: No minimum service	benefits after 10 years of full service.
	requirement.	
Death Benefit:	Member contribution accumulation (member	Total accumulations in a member's basic retirement plan.
Beneficiar(ies)	contributions +interest) + death benefit equal to one	
of <u>Active</u>	year's salary for one year of service, two years' salary	
Employees in	for two years of service and three years' salary for	
Basic Pension	three or more. Reductions may be applicable	
	depending on age.	
Loans	Yes, to the maximum allowable by law from a	Yes, to the maximum allowable by law from a member's
	member's contributions to basic retirement plan,	basic retirement plan, TDA, 457 (b) and 401 (k) plans.
	TDA, 457 (b) and 401 (k) plans.	

^{*}The preceding is for information al purposes only. It is a preliminary interpretation of 2012 Tier VI legislation & subject to change.

HOW TO ENROLL ONLINE

TIAA-CREF has made it easy for you to enroll online in the CUNY retirement program.

BE READY WITH YOUR:

- **■** Investment choices and allocations
 - Go to **www.tiaa-cref.org/cuny** to review your investment choices including:
 - One-Decision Strategy Allocate 100% of your investment to the TIAA-CREF Lifecycle Fund closest to your estimated year of retirement.
 - Build Your Own Portfolio Strategy Indicate the percentage of your contribution you want allocated to each fund/account you choose.
- Social Security Number
- Beneficiary's Social Security Number (optional), birth date and address

TO ENROLL ONLINE:

LOG IN TO www.tiaa-cref.org/cuny AND CLICK "ENROLL NOW"

- Click on the link for the plan(s) you want to enroll in.
- Follow the on-screen directions to complete your enrollment application.

NOTE: At the allocations screen, you can click on any investment choice to view its fact sheet.

Once you complete your enrollment, you can retrieve and print a confirmation page from the "Congratulations" screen.

IMPORTANT:

If you participate in the Voluntary Savings Program (Tax-Deferred Annuity), you **must** complete and submit a Salary Reduction Agreement form for your enrollment application to be processed.

COMPLETE YOUR SALARY REDUCTION AGREEMENT

You may be able to access your agreement at **tiaa-cref.org/cuny**. If so, download and print it, fill it out, and return it to your Benefits Office. If it is not available, get an agreement from your Benefits Office. Complete it and return it to your Benefits Office.

HELP IS READY FOR YOU

If you need assistance with enrolling online, call TIAA-CREF at **800 842-2776**, Monday through Friday, from 8 a.m. to 10 p.m., and Saturday from 9 a.m. to 6 p.m. (ET). We will guide you through the online enrollment process.

Any withdrawals you make from your account may be subject to ordinary income tax and an additional 10% federal tax may apply if you make a withdrawal prior to age 59½. There are risks when investing in securities, including Lifecycle Funds. Read the prospectus before making any investment choices.

You should consider the investment objectives, risks, charges and expenses carefully before investing. Please call 877 518-9161 or go to tiaa-cref.org for a prospectus that contains this and other information. Please read the prospectus carefully before investing. TIAA-CREF Individual & Institutional Services, LLC, and Teachers Personal Investors Services, Inc., members FINRA, provide advisory services and distribute securities products. TIAA (Teachers Insurance and Annuity Association), New York, NY issues annuities. FINANCIAL SERVICES FOR THE GREATER GOOD is a registered trademark of Teachers Insurance and Annuity Association.

©2008 Teachers Insurance and Annuity Association-College Retirement Equities Fund (TIAA-CREF), New York, NY 10017





WageWorks[®]

TRANSITBENEFIT PLANS

Submit comple	ted for	m to: Your College Ti	ransi	itBenefit Coord	linator		www.cuny.ed	du/transitbenefit	www.getwageworks.com/nyo
EMPLOYEE	ACTIC	N							
NEW (Enroll)		HANGE PERSONAL INFO nange Mailing address, Email		ephone) (Ch	ange Trans	EDUCTION it Plan and/or Amo n Pay each Month)	unt (Te	USPEND DEDUCTION emporarily Stop Transit Plan Deduction from Pay)	CANCELLATION (Terminate Your Transit Plan Payroll Deduction)
EMPLOYEE	IDENT	IFICATION (All field	ls in t	his section are re	quired ar	nd must be fille	d out comple	etely. Please Print.)	
Social Security /	ERN								DOB MM/DAY
Name (First/Middle	/Last)								
Address Line 1									
Address Line 2*	*								
City/State/Zip									
Email Address							Telephone	,	
* Located on your pa	ıy stateme	nt or check stub.	** Ap	t.#, Fl.# or Box# if app	olicable.			•	
TRANSIT PLA	AN AU							olumn next to the Transit Pl	
(\$3.0	5 Month	F-A-RIDE ly Admin Fee Il Deductions)		(\$1	.77 Month	RD - Unrest nly Admin Fee oll Deductions)	ricted	(\$3.05 N	ANSIT PASS Monthly Admin Fee Payroll Deductions)
Employee Initials		Monthly Deduction Amount	*	Employe Initials	е	Mont Deduction		Employee Initials	Monthly Deduction Amount*
		\$				\$			\$
For the Commuter Car	rd – Unres	tricted, Transit Pass and Acce	ss-A-R	Ride plans you may ele	ect any amo	ount up to \$800			
SUSDEND TE	V VICI.	T PLAN DEDUCTION) N						
the parking plan will to www.wageworks.co	oe suspend om or 1-87	ded for the same period. Pleas		this will only suspend		I deduction. To also	suspend your to	ransit pass orders you must d	e Commuter Benefits Parking Plan, lo so directly with Wageworks at MONTH DAY YEAR
EMPLOYEE (CERTI	FICATION							
I also grant authoriza guidelines and rules, I understand, accordi work. If my average provided for pre-tax to	tion for the The City L ng to the I monthly co	est of public transportation to a	ount in reverse averand fron ncellati	the event the credit was the amount of the irage monthly amount of n work should change, ion, voluntary or other	ras made in neorrect dire of my transport, I will chang wise, any fu	error. I understand ect deposit. ortation deductions ge my deduction pla nds remaining in m	that, under the "should not exceed to accommodal	'National Automated Clearing ed my average monthly cost of ate my new circumstance. Fu	House Association" operating of public transportation to and from urthermore, no reimbursement will be a period of 90 days from the effective
I understand there is fees and charges are			sts of th	ne program. Said fee v	vill deducted	d from my post-tax	pay each month.	The administrative charge is	non-refundable. The administrative
TRANSIT PLAN Access-A-Ride			FE	.05		CHARGE I	METHOD rom post-tax pay		
Commuter Card-Unres	stricted			.77		Deducted f	rom post-tax pay.		
I grant authorization f administration of the I understand that this	program. authorizat Commute geWorks (*	tion will remain in effect until I s	vide m	y enrollment informati	nange or car	g mailing address,	phone number a	lline at www.wageworks.con	orks for uses exclusively related to the n or by calling Wageworks Customer MONTH DAY YEAR ATE
4.051101/ 5.11	/DC::	05071011							
Payroll #	rKULL	. SECTION	Perso	onal information updat Mailing Address	Ém	erv / PMS (check a nail Idress	I that apply): Phone Number	PAYSERV / PMS ENTRY DATE	MONTH DAY YEAR
I certify that the above	e data was	entered in PMS via EForms:							
Prepared By (Plea	ase Print)		Sign	nature					Date

WageWorks[®]

THE CITY UNIVERSITY OF NEW YORK COMMUTER BENEFITS PROGRAM PARK-N-RIDE PLAN

Submit completed form to: Your College TransitBenefit Coordinator.

www.cuny.edu/transitbenefit

www.getwageworks.com/nyc

	RMATION FOR EM	PLOTEE							
To enroll in the Commuter Benefits Program Park-n-Ride Plan, you must be jointly enrolled in one of the following Commuter Benefits Program TransitBenefit Plans: Commuter Card Plan or the Transit Pass Plan.						r the			
Only Parking expenses at or near a public transportation stop or station that you use to commute to work are eligible under this plan. With the Park-n-Ride plan, you pay an administrative fee of \$3.05 per month through payroll deductions.							fee of		
In this plan, you fund a parkin offers three parking payment	g account with WageWorks woptions: • Pay My Parking • I		st-tax payroll d Pay Me Back.	eductions and you	ı select your Park-r	n-Ride payn	nent opti	on on the WageWorks system. W	ageWorks
Two business days after you e Eastern Time, to select your p	enroll in the Park-n-Ride Plan,	go to www.wageworks	•	ageWorks at 1-877	-WageWorks (1-877	7-924-3967)	Monday	through Friday, from 8 a.m. to 8 p.	m.
			· · · · · · · · · · · · · · · · · · ·		1450	***************************************			
TRANSITBENEFIT		next to the p	lan.		***	which you	are enro	lled by writing your initials in the	column
COMMUTER CAR Unrestricted	RD Employee Initial	s TRAI	NSIT PAS	S Em	ployee Initials				
EMPLOYEE ACTIO	N						William Contract on Association Association		
(Enroll) INFO	NGE PERSONAL DRMATION nge Mailing Address, e, Email or Telephone)	CHANGE DEDUC* (Change Amount Dedition Pay each Month)	ucted	SUSPEND DE (Temporarily Stor from Pay)		(End Su		Resume CANCELLA (Terminate Par Deduction)	
EMPLOYEE IDENTI	FICATION (All fields	in this section are	required an	d must be filled	d out completely	y. Please	Print.)	MONTH DAY Y	EAR .
Social Security #								D.O.B	
Name (First/Middle/Last)					Marine constant and a	on the second			
Address Line 1	PROCESSOR CONTRACTOR C			-	Address Line	2**		***************************************	
City/State/Zip		,	······································	-			75-55560 ad 1007/cm 11 ac 11 ac 11		
Email Address	~			Telephone					
** Apt.#, Fl.# or Box# if ap	olicable.								
PARK-N-RIDE DED	UCTION AUTHORI	ZATION						<u>.</u>	
Please enter the total amount, i	n dollars and cents, you want o	leducted from your pay	oach month			1			
			each month.	Monthly Dedu	iction Amount	\$			
SUSPEND OR RESU	JME PARK-N-RIDE		each month.	Monthly Dedi	iction Amount	\$			
Submit at least 2 weeks before y	rou want to suspend your deduc the action you are authorizing. Ride payment options you must	DEDUCTION tion from pay or when you Remember, administrativ	ou want to resun	ne the deduction from	m being withheld from	n pay. A ser	parate fori	m will be required to resume the ded id or resume your payroll deduction.	uction. To also
Submit at least 2 weeks before y Please place your initials next to	rou want to suspend your deduc the action you are authorizing. Ride payment options you must	DEDUCTION tion from pay or when yo Remember, administrati do so directly with Wage DAY YEAR	ou want to resun	ne the deduction froi ill continue when ap wageworks.com o	m being withheld from	n pay. A sep e this will or	ly susper	nd or resume your payroll deduction.	uction. To also
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-n-	rou want to suspend your deduct the action you are authorizing. Ride payment options you must MONTH DEDUCTION	DEDUCTION tion from pay or when yo Remember, administrati do so directly with Wage DAY YEAR	ou want to resun ve deductions w eworks at www.	ne the deduction froi ill continue when ap wageworks.com o	m being withheld fror plicable. Please not r 1-877-924-3967.	n pay. A sep e this will or	ly susper	nd or resume your payroll deduction.	To also
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-n- PAY DATE TO SUSPEND	rou want to suspend your deduct the action you are authorizing. Ride payment options you must be DEDUCTION MONTH TO DEDUCTION	DEDUCTION tion from pay or when yo Remember, administrativ do so directly with Wage DAY YEAR	ou want to resun ve deductions w eworks at www.	ne the deduction froi iil continue when ap wageworks.com o	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE	m pay. A sep e this will on	N MONT	nd or resume your payroll deduction.	To also
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-n-PAY DATE TO SUSPENDE EMPLOYEE CERTIL I hereby authorize The City Univ	rou want to suspend your deduct the action you are authorizing. Ride payment options you must DEDUCTION MONTH CONTROL OF THE ACTION PROVIDED TO SET THE ACTION PROVIDED TO SET THE ACTION TO SET	DEDUCTION tion from pay or when yo Remember, administrativ do so directly with Wage DAY YEAR YEAR y payroll deduction as in Int in the event the credit	bu want to resun ve deductions we eworks at www. Employee Initials Indicated above in t was made in e	ne the deduction froi ill continue when ap wageworks.com o PAY DATE 1	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE	m pay. A sepet this will on	MONT N Count.	nd or resume your payroll deduction.	To also
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-n-PAY DATE TO SUSPENDED TO	Tou want to suspend your deduct the action you are authorizing. Ride payment options you must be DEDUCTION MONTH TO DEDUCTION FICATION Persity of New York to deposit m reversal of a credit to my account New York can only reverse the tisemal Revenue Code, that the ublic transportation to and from	DEDUCTION tion from pay or when you Remember, administration do so directly with Wage DAY YEAR y payroll deduction as in the event the credit amount of the incorrect an everage monthly amount work should change, I was	bu want to resun ve deductions we eworks at www. Employee Initials dicated above in t was made in e direct deposit. at of my transpor ill change my de	ne the deduction froi ill continue when ap wageworks.com o PAY DATE 1 nto my WageWorks rror. I understand the tation deductions standard	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE Commuter Benefits nat, under the "Nation nould not exceed my ommodate my new ommodate my new exceed my new ex	m pay. A ser e this will or EDUCTIO	N MONTO	nd or resume your payroll deduction. TH DAY YEAR Employ Ing House Association" operating guiltst of public transportation to and from the processor, no reimbursement will be or	To also yee initials delines
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-new PAY DATE TO SUSPENDED	rou want to suspend your deduct the action you are authorizing. Ride payment options you must be DEDUCTION MONTH of DEDUCTION PICTURE TO THE PROPERTY OF THE P	DEDUCTION tion from pay or when yo Remember, administrativ do so directly with Wage DAY YEAR y payroll deduction as in int in the event the credit amount of the incorrect average monthly amoun work should change, I w voluntary or otherwise, a	bu want to resun ve deductions we eworks at www. Employee Initials dicated above in t was made in e direct deposit. t of up transpor ill change my de any funds remai deducted from r	ne the deduction froi ill continue when ap wageworks.com o PAY DATE 1 not o my WageWorks rror. I understand the tation deductions stated deduction plan to accoming in my Parking and prost-tax pay each	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE Commuter Benefits nat, under the "Nation nould not exceed my ommodate my new account will be forfeith month my account	m pay. A seperent of the separation of the separ	count. ed Clearionthly coe. Further effective door purchas	nd or resume your payroll deduction. TH DAY YEAR Employ Ing House Association" operating guidest of public transportation to and from the properties of the properties of cancellation. THE DAY YEAR Employ THE DAY YEAR Employ THE DAY YEAR Employ THE DAY YEAR Employ THE DAY YEAR THE DA	ree Initials delines n work.
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-n-PAY DATE TO SUSPENDE EMPLOYEE CERTIL I hereby authorize The City Univ. I also grant authorization for the and rules, The City University of I understand, according to the Ir If my average monthly cost of put for pre-tax transportation fringe I understand that \$3.05 per moncharge is non-refundable. In additional propertical p	rou want to suspend your deduct the action you are authorizing. Ride payment options you must be DEDUCTION MONTH of DEDUCTION PICTURE TO THE PROPERTY OF THE P	DEDUCTION tion from pay or when yo Remember, administrative do so directly with Wage DAY YEAR y payroll deduction as in int in the event the credit amount of the incorrect average monthly amoun work should change, I w voluntary or otherwise, cof the program, will be pay for Park-N-Ride, I m	Employee Initials dicated above in twas made in e direct deposit. It of many funds remainded and funds for the form of the fo	ne the deduction froi ill continue when ap wageworks.com o PAY DATE 1 not o my WageWorks rror. I understand the tation deductions standard plan to accoming in my Parking and propost-tax pay each ther Commuter Plan	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE Commuter Benefits nat, under the "Nation mould not exceed my ommodate my new account will be forfeith month my account and pay the admin	m pay. A septent of this will or earlier or the septent of the sep	MONT N MONT Need Cleari onthly core. Further ffective door purcher associate	nd or resume your payroll deduction. TH DAY YEAR Employ Ing House Association" operating guidest of public transportation to and from the properties of the properties of cancellation. THE DAY YEAR Employ THE DAY YEAR Employ THE DAY YEAR Employ THE DAY YEAR Employ THE DAY YEAR THE DA	delines work.
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-new PAY DATE TO SUSPEND EMPLOYEE CERTIL I hereby authorize The City University of I understand, according to the Irl fr my average monthly cost of pr for pre-tax transportation fringe of understand that \$3.05 per moncharge is non-refundable. In add I grant authorization for The City administration of the program. I understand that this authorization transportation for The City administration of the program.	rou want to suspend your deduct the action you are authorizing. Ride payment options you must be DEDUCTION MONTH of DEDUCTION PERSITY of New York to deposit more versal of a credit to my accounty. New York can only reverse the atternal Revenue Code, that the ablic transportation to and from the control of the control of the administrative costs dition to the administrative feel of University of New York to provious will remain in effect until I su	peduction tion from pay or when yo Remember, administrati do so directly with Wage DAY YEAR y payroll deduction as in nt in the event the credit amount of the incorrect average monthly amoun work should change, I w voluntary or otherwise, a or of the program, will be or or park-N-Ride, I m de my enrollment inform mit a new request for a	bu want to resun ve deductions we works at www. Employee Initials Idicated above in t was made in e direct deposit. In formy transpor ill change my de any funds remai deducted from r ust enroll in and action, including	pe the deduction froi ill continue when ap wageworks.com o PAY DATE 1 The pay of the pay of the pay of the pay of the tation deductions steaduction plan to acc pay of the pay of the pay of the pay of the pay of the pay of the pay of the pay o	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE Commuter Benefits nat, under the "Nation nould not exceed my ommodate my new account will be forfer h month my account in and pay the adminione number and e-responsible.	m pay. A seperent of this will or extended on the exist debited fisher is address.	N MONT Count. ed Clearing the Count on the Count on the Count of the Count on the Count of the C	nd or resume your payroll deduction. TH DAY YEAR Employ Ing House Association" operating guidest of public transportation to and from the properties of cancellation. In the DAY YEAR Employees and the properties of public transportation to and from the properties of cancellation. In the DAY YEAR Employees and the properties of public transportation of properties of public transportation of properties of public transportations and the properties of the pr	delines a work. byided titive
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-new PAY DATE TO SUSPEND EMPLOYEE CERTIL I hereby authorize The City University of I understand, according to the Irl fr my average monthly cost of pr for pre-tax transportation fringe of understand that \$3.05 per moncharge is non-refundable. In add I grant authorization for The City administration of the program. I understand that this authorization transportation for The City administration of the program.	Tou want to suspend your deduct the action you are authorizing. Ride payment options you must be provided by the action of the a	DEDUCTION tion from pay or when yo Remember, administration do so directly with Wage Day YEAR y payroll deduction as in not in the event the credit amount of the incorrect amount of the incorrect amount of the program, will be only to pay for Park-N-Ride, I middle my enrollment informomit a new request for a since and information will be only to pay for a since and information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for pay for park-N-Ride, I middle my enrollment information will be only to pay for	Employee Initials dicated above in twas made in e direct deposit. at of my transpor ill change my de any funds remai deducted from rust enroll in ancuation, including a change or cancoe maintained b	ne the deduction froi ill continue when ap wageworks.com o PAY DATE 1 The pay of the pay of the pay into my WageWorks fror. I understand the tation deductions standard of the tation plan to accoming in my Parking in my post-tax pay each the Commuter Plan mailing address, photellation.	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE Commuter Benefits nat, under the "Nation nould not exceed my ommodate my new account will be forfeith month my account n and pay the adminione number and e-reking Account orders	n pay. A seperent of this will or each of the each of this will be each of	MONTAL COUNTS. COUNT	nd or resume your payroll deduction. THE DAY YEAR TEMPORE Ing House Association" operating guist of public transportation to and fror armore, no reimbursement will be preate of cancellation. Sees and/or charges. The administrated with that plan. Works for use exclusively related to constant of the preated to constant of the plan.	ree Initials delines n work, wided titive the
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-n-PAY DATE TO SUSPEND EMPLOYEE CERTIL I hereby authorize The City University of lunderstand, according to the Information for pre-tax transportation fringe of lunderstand that \$3.05 per morn charge is non-refundable. In additional authorization for The City administration of the program. I understand that this authorization I understand that this commuter I understand that this Commuter I understand that this Commuter I understand that my Co	Tou want to suspend your deduct the action you are authorizing. Ride payment options you must be provided by the action of the a	DEDUCTION tion from pay or when yo Remember, administration do so directly with Wage Day YEAR y payroll deduction as in not in the event the credit amount of the incorrect amount of the incorrect amount of the program, will be only to pay for Park-N-Ride, I middle my enrollment informomit a new request for a since and information will be only to pay for a since and information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for pay for park-N-Ride, I middle my enrollment information will be only to pay for	Employee Initials dicated above in twas made in e direct deposit. at of my transpor ill change my de any funds remai deducted from rust enroll in ancuation, including a change or cancoe maintained b	ne the deduction froi ill continue when ap wageworks.com o PAY DATE 1 The pay of the pay of the pay into my WageWorks fror. I understand the tation deductions standard of the tation plan to accoming in my Parking in my post-tax pay each the Commuter Plan mailing address, photellation.	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE Commuter Benefits nat, under the "Nation nould not exceed my ommodate my new account will be forfeith month my account n and pay the adminione number and e-reking Account orders	n pay. A seperent of this will or each of the each of this will be each of	MONTAL COUNTS. COUNT	nd or resume your payroll deduction. TH DAY YEAR Employ Ing House Association" operating guidest of public transportation to and from the properties of cancellation. See and/or charges. The administrated with that plan. Works for use exclusively related to the properties of th	delines a work. byided titive
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-n-PAY DATE TO SUSPEND Interest and the suspend or resume your Park-n-PAY DATE TO SUSPEND Interest and release the suspend or the and rules, The City University of I understand, according to the Infi my average monthly cost of pure for pre-tax transportation fringe of I understand that \$3.05 per mon charge is non-refundable. In addingrant authorization for The City administration of the program. I understand that this authorization I understand that this authorization of the program.	FICATION FICATION FICATION Presity of New York to deposit m reversal of a credit to and from yelden actions. Upon cancellation, the to cover administrative costs dition to the administrative fee I university of New York can only reverse the ablic transportation to and from yeldeductions. Upon cancellation, the to cover administrative fee I university of New York to provion will remain in effect until I su Benefits Parking Account balar formation is accessible online a	DEDUCTION tion from pay or when yo Remember, administration do so directly with Wage Day YEAR y payroll deduction as in not in the event the credit amount of the incorrect amount of the incorrect amount of the program, will be only to pay for Park-N-Ride, I middle my enrollment informomit a new request for a since and information will be only to pay for a since and information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for pay for park-N-Ride, I middle my enrollment information will be only to pay for	Employee Initials dicated above in twas made in e direct deposit. at of my transpor ill change my de any funds remai deducted from rust enroll in ancuation, including a change or cancoe maintained b	ne the deduction froi ill continue when ap wageworks.com o PAY DATE 1 The pay of the pay of the pay into my WageWorks fror. I understand the tation deductions standard of the tation plan to accoming in my Parking in my post-tax pay each the Commuter Plan mailing address, photellation.	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE Commuter Benefits nat, under the "Nation nould not exceed my ommodate my new account will be forfeith month my account n and pay the adminione number and e-reking Account orders	n pay. A seperent of this will or each of the each of this will be each of	MONTAL COUNTS. COUNT	nd or resume your payroll deduction. TH DAY YEAR Employ Ing House Association" operating guidest of public transportation to and from the properties of cancellation. In the properties of t	ree Initials delines n work, wided titive the
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-n-PAY DATE TO SUSPEND In Park	FICATION FICATION FICATION Presity of New York to deposit m reversal of a credit to and from yelden actions. Upon cancellation, the to cover administrative costs dition to the administrative fee I university of New York can only reverse the ablic transportation to and from yeldeductions. Upon cancellation, the to cover administrative fee I university of New York to provion will remain in effect until I su Benefits Parking Account balar formation is accessible online a	DEDUCTION tion from pay or when yo Remember, administration do so directly with Wage Day YEAR y payroll deduction as in not in the event the credit amount of the incorrect amount of the incorrect amount of the program, will be only to pay for Park-N-Ride, I middle my enrollment informomit a new request for a since and information will be only to pay for a since and information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for park-N-Ride, I middle my enrollment information will be only to pay for pay for park-N-Ride, I middle my enrollment information will be only to pay for	Employee Initials dicated above in the way and the way funds remainded ucted from roust enroll in and the way funds remainded ucted from roust enroll in and the way and the way funds remainded the way funds remainded the way funds remainded the way funds remainded the way funds and the way funds remainded to the way funds remainded to the way funds and the way funds and the way funds the way funds and the way funds	ne the deduction froi ill continue when ap wageworks.com o PAY DATE 1 The man wageworks fror. I understand the tation deductions of adduction plan to according in my Parking and my post-tax pay each ther Commuter Plan mailing address, phosellation.	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE Commuter Benefits nat, under the "Nation nould not exceed my ommodate my new account will be forfeith month my account n and pay the adminione number and e-riking Account orders er Service at 1-877-1	n pay. A seperent of this will or each of the each of this will be each of	MONTAL COUNTS. COUNT	nd or resume your payroll deduction. TH DAY YEAR Employ Ing House Association" operating guidest of public transportation to and from the properties of cancellation. In the properties of t	ree Initials delines n work, wided titive the
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-n-PAY DATE TO SUSPEND EMPLOYEE CERTIL I hereby authorize The City University of I understand, according to the Ir fmy average monthly cost of py for pre-tax transportation fringe I understand that \$3.05 per moncharge is non-refundable. In add I grant authorization for The City administration of the program. I understand that this authorizati I understand that my Commuter order processing and balance in Employee Signature	FICATION FICATION FICATION Presity of New York to deposit m reversal of a credit to and from yelden actions. Upon cancellation, the to cover administrative costs dition to the administrative fee I university of New York can only reverse the ablic transportation to and from yeldeductions. Upon cancellation, the to cover administrative fee I university of New York to provion will remain in effect until I su Benefits Parking Account balar formation is accessible online a	peduction tion from pay or when yo Remember, administrativ do so directly with Wage DAY YEAR y payroll deduction as in int in the event the credit amount of the incorrect average monthly amoun wyoluntary or otherwise, a of the program, will be o pay for Park-N-Ride, I m de my enrollment inform pomit a new request for a sce and information will be t www.wageworks.com	Employee Initials dicated above in twas made in e direct deposit. It of the properties of the propert	ne the deduction froi ill continue when ap wageworks.com o PAY DATE 1 The man wageworks fror. I understand the tation deductions of adduction plan to according in my Parking and my post-tax pay each ther Commuter Plan mailing address, phosellation.	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE Commuter Benefits nat, under the "Nation nould not exceed my ommodate my new account will be forfeith month my account n and pay the adminione number and e-riking Account orders er Service at 1-877-1	m pay. A sere e this will or e this	count. count. countly core. Further ffective door purchassociate to Wage code direct (1-877-9)	nd or resume your payroll deduction. TH DAY YEAR TEMPORE IN THE DAY YEAR Employ Ing House Association" operating guing the second of the properties of public transportation to and from the properties of th	delines n work. byided titive the
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-n-PAY DATE TO SUSPEND EMPLOYEE CERTIL I hereby authorize The City University of I understand, according to the Irif my average monthly cost of pure for pre-tax transportation fringe I understand that \$3.05 per moncharge is non-refundable. In add I grant authorization for The City administration of the program. I understand that this authorizati I understand that my Commuter order processing and balance in Employee Signature	rou want to suspend your deduct the action you are authorizing. Ride payment options you must be provided by the action of the a	peduction tion from pay or when yo Remember, administrativ do so directly with Wage DAY YEAR y payroll deduction as in nt in the event the credit and the incorrect average monthly amoun work should change, I w voluntary or otherwise, a of the program, will be o pay for Park-N-Ride, I m de my enrollment inform the program of the work of the program of the work of the program of the work of the program of th	Employee Initials Employee Initials dicated above in the way of	ne the deduction froi ill continue when ap wageworks.com o PAY DATE 1 The major of	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE Commuter Benefits nat, under the "Nation mould not exceed my ommodate my new account will be forfeith month my account n and pay the adminione number and e-received at 1-877-1.	m pay. A sere e this will or e this	count. count. countly core. Further ffective door purchassociate to Wage code direct (1-877-9)	ng House Association" operating guist of public transportation to and from the promote of cancellation. Bess and/or charges. The administrate of with that plan. Beworks for use exclusively related to the through WageWorks. Parking Act 24-3967). MONTH DAY MONTH DAY	delines n work. byided titive the
Submit at least 2 weeks before y Please place your initials next to suspend or resume your Park-n-PAY DATE TO SUSPEND EMPLOYEE CERTIL I hereby authorize The City University of Lunderstand, according to the Information for pre-tax transportation fringe of Lunderstand that \$3.05 per moncharge is non-refundable. In adding a grant authorization for The City administration of the program. I understand that this authorization I understand that this authorization of the program. I understand that my Commuter order processing and balance in Employee Signature	rou want to suspend your deduct the action you are authorizing. Ride payment options you must be provided by the action of the a	peduction tion from pay or when yo Remember, administrativ do so directly with Wage DAY YEAR y payroll deduction as in nt in the event the credit and the incorrect average monthly amoun work should change, I w voluntary or otherwise, a of the program, will be o pay for Park-N-Ride, I m de my enrollment inform the program of the work of the program of the work of the program of the work of the program of th	Employee Initials Employee Initials dicated above in the way of	ne the deduction froi ill continue when ap wageworks.com o PAY DATE 1 The major of	m being withheld fror plicable. Please not r 1-877-924-3967. FO RESUME DE Commuter Benefits nat, under the "Nation mould not exceed my ommodate my new account will be forfeith month my account n and pay the adminione number and e-received at 1-877-1.	m pay. A sere e this will or e this	count. count. countly core. Further ffective door purchassociate to Wage code direct (1-877-9)	ng House Association" operating guist of public transportation to and from ermore, no reimbursement will be preate of cancellation. asses and/or charges. The administrated with that plan. BWorks for use exclusively related to the transportation to and from ermore, no reimbursement will be preate of cancellation. But the preate of the	delines n work. byided titive the

Form Approved OMB No. 1210-0149 (expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your College Health Benefits or Human Resources Office. Get the SPD at www.psccunywf.org

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name:	4. Employer Identification	Number (EIN)		
City University of New York	13-6400434			
5. Employer Address	6. Employer phone Numb	er		
205 E 42 Street	N/A			
7. City	8. State	9. Zip Code		
New York	NY	10017		
10. Who can we contact about employee health coverage at this job?				
Employee's College Health Benefits or Human R	esources Office			
11. Phone number (if different from above)	12. Email Address			
212-354-5230	N/A			

Here is	some	e basic information about health coverage offered by this employer:
•		our employer, we offer a health plan to:
		All employees.
		Some employees. Eligible employees are:
		Certain part-time employees classified as adjuncts and who meet credit hour and longevity criteria may receive basic health insurance through their union's Welfare Fund. Refer to that SPD at www.psccunywf.org
•	With	respect to dependents: We do offer coverage. Eligible dependents are:
		legal spouse, certified domestic partner, children under age 26 as follows: natural children, adopted children, children under a medical support court order, children for whom employee is the legal guardian, children who are the employee's tax dependent, health plan certified disabled children. See the SPD for more info at www.psccunywf.org
		We do not offer coverage.
V		ecked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to ffordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.