

# Health Plan Enrollment/Change Form

For Active NYCT TWU Local 100 & MTA Bus TWU Local 100 Employees

HR-BEN-812A



## Section 1 - Information & Instructions

Complete this form to enroll in or change your health insurance coverage. This form is only for Active NYCT TWU Local 100 & MTA Bus TWU Local 100 employees and/or their dependent(s).

It is important to complete **ALL** applicable sections of this form. You **MUST** submit a new request if there are any changes in the below information. Completed and signed forms **must** be submitted via fax to 212-852-8700 OR via email to [bsc-benefits@mtabsc.org](mailto:bsc-benefits@mtabsc.org) for processing.

If you have questions, you must call the Business Service Center (BSC) at 646-376-0123, 8:30AM - 5:00PM, Monday to Friday, OR email [bscservice@mtabsc.org](mailto:bscservice@mtabsc.org).

## Section 2 - Employee Information

Print Name	Last	First	M.I.	BSC ID#
Phone (Cell)	Phone (Home)			Personal E-Mail

Your health insurance cards will be mailed to the address on your pay stub. If your address is incorrect, please log onto [www.mymta.info](http://www.mymta.info) to update your address or to obtain the **HR-HRIS-012 Employee Data Change Form**. An incorrect address will delay receipt of your new health insurance cards.

## Section 3 - Medical Coverage Election

**MEDICAL:** Individual ☐ Family ☐

Check only **ONE**:

☐ **AETNA CPOS II BASIC OPTION**

☐ **AETNA CPOS II HIGH OPTION** (Includes EmblemHealth Preferred Dental Coverage)

✓ **Required** bi-weekly, pre-tax contribution of \$13.17 for Individual Coverage and \$26.34 for Family Coverage

✓ Dependent children, regardless of full-time student status, are only eligible for dental coverage through the end of the month they attain age 21

☐ **AETNA SELECT OPTION** (National in-network only providers: Allows you to see Aetna participating providers within the United States)

**You MUST direct questions about dental, vision, and other benefits to your respective union.**

### WAIVING COVERAGE

☐ **I DO NOT WISH TO ENROLL IN MTA-SPONSORED HEALTH BENEFITS COVERAGE\*\*\***

\*\*\*Your election to waive coverage will remain in effect until you change your election during a future open enrollment period or if you experience a qualifying life event, such as marriage, birth, divorce, or loss of alternate medical coverage, during the year. Please contact the BSC at 646-376-0123 for additional assistance.

**Please Note:** Waiving your enrollment in the MTA-sponsored medical plan is not the same as opting-out of medical coverage and participating in the MTA's Medical Opt-Out Program. Waiving your coverage will not automatically qualify you to receive an opt-out incentive payment. Participation in the opt-out program is only available during the annual open enrollment period and requires the completion and submission of the applicable opt-out form to the BSC.

## Section 4 - Dependent Information

### ADD, REMOVE, OR CHANGE DEPENDENT(S):

Please complete all information for dependents you wish to add (enroll), remove (delete), or change. The required supporting documentation (see Section 6 of this form) is only required if you are adding a new dependent, removing a spouse due to divorce, or changing a current dependent's biographical information. Use a separate sheet if more space is needed to list additional dependents.

For **Newborns**: Supporting documentation is required within ninety (90) days of a newborn's birth to remain enrolled in MTA-sponsored benefits. Failure to provide all required documentation within this timeframe will result in the retro-termination (to date of birth) of the newborn from your health coverage.

For **Divorce**: Supporting documentation is required within thirty-one (31) days of the divorce date in order to remove an ex-spouse from health coverage.

If you are found to be covering an ineligible dependent, coverage will be terminated retroactive to the date of the ineligibility and New York City Transit (NYCT) will pursue financial restitution for claims and/or premiums paid for the ineligible dependent(s).

### DOMESTIC PARTNER^:

Please contact the MTA Business Service Center for the Domestic Partnership Package if you wish to enroll a domestic partner. Your domestic partner will not be enrolled in health coverage unless a Domestic Partner Package is submitted and approved by the Benefits Department. If you are removing a Domestic Partner, please complete and submit this enrollment/change form along with the required NYCT Termination of Domestic Partnership Form.

Indicate (A) Add, (R) Remove, or (C) Change					Relationship (Check only <u>ONE</u> )			Gender			Date of Birth		
A	R	C	Full Name	SSN	Spouse	Domestic Partner^	Child	F	M	X	MM	DD	YYYY

MTA Business Service Center

Last Revised: 05/08/2024

Creation Date: 02/27/2024

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## Section 5 - Signature & Authorization

I do hereby certify that to the best of my knowledge, the above information is true and correct. My signature and date on this form certifies and warrants all dependent eligibility information is true, correct, and current.

I also certify that all dependent children I have enrolled, including those aged 19 to 26, are eligible for MTA-sponsored coverage.

Employee Signature:

Date:

## Section 6 - Required Supporting Documentation

### 1. For a Spouse:

A copy of your official governmental (non-religious) Marriage Certificate (religious documents will **not** be accepted), spouse's Birth Certificate, and spouse's Social Security Card are **required**. In place of the required Birth Certificate, any one (1) of the following official government documents can be alternatively submitted:

- Letter from Social Security Administration containing your spouse's date of birth
- Valid US Passport **or** Resident Alien Card
- Valid Driver's License (New York)
- Public Assistance ID Card
- Government Employment ID

**AND**

If your date of marriage is **more than one (1) year old**, proof of joint ownership is also **required**. If your marriage date is **less than 1 year old**, such proof is **not required**.

If removing a spouse due to divorce, submit the first and last page of the divorce decree filed by the County Clerk's Office.

Both the enrollee's and spouse's name **must** be listed on the documentation of joint ownership. Where indicated, proof\* of joint ownership **must** be dated within the past 90 days. Examples of proof of joint ownership include a copy of:

- Most recent tax return showing "Married Filing Jointly" or "Married Filing Separately". Your spouse's name **must** appear on the tax form on the line after the "Married Filing Separately" status (or vice versa). Submit page 1 of tax return.
- Homeowners/Renters Insurance Policy
- Credit Card Statement\*
- Loan Obligation **or** Bank Account Statement\*
- Pension **or** Life insurance **or** Will, designating your spouse as a beneficiary
- Mortgage Statement **or** Rental/Lease Agreement **or** Property Tax Document\*
- Utility **or** Phone **or** Internet/Cable Bill\*

### 2. For Children:

For a Natural-Born Child, a copy of:

- Birth Certificate showing employee's name\*\*
- Social Security Card

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

- Birth Certificate\*\*
- Social Security Card
- Legal documentation concerning adoption/guardianship

**\*\*Due to Puerto Rico's Birth Certificate Law, Puerto Rican Birth Certificates issued prior to July 1, 2010 are invalid, and will not be accepted.**