CIGNA Health Plan Enrollment/Change Form

For Metro-North (MNR) & MTA Police Active Employees & Retirees

HR-BEN-068A

Section 1 - Information & Instructions

Complete this form to enroll in **or** change your CIGNA medical insurance coverage. This form is only for Metro-North (MNR) and MTA Police active employees/retirees and/or their dependent(s) who are eligible for the CIGNA Health Plan. **ONLY MNR and MTA Police active employees and retirees who reside in the state of Connecticut are eligible to enroll in the CIGNA Health Plan**.

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 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.

Section 2 - Employee/Retiree Information

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

IMPORTANT REMINDER: For active employees, your health insurance cards will be mailed to the address on your pay stub. For active employees and retirees, if your address is incorrect, you **must** log onto **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 health insurance cards and other important benefits-related information from carriers.

Section 3 - Medical Coverage Elections

Election Type:	☐ New Enrollment	☐ Reinstatement/Change
Coverage Level:	☐ Individual	☐ Family
Change of Status:	☐ Add Dependent	☐ Remove Dependent

WAIVING COVERAGE

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

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 to ***specific eligible active employees*** during the annual open enrollment period and **requires** the completion and submission of the applicable opt-out form to the BSC. Please contact the MTA BSC for additional information on eligibility for the MTA's Medical Opt-Out Program.

☐ **I DO NOT wish to enroll in MTA-Sponsored Dental Coverage*****

☐ **I DO NOT wish to enroll in MTA-Sponsored Vision 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.**

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 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 financial restitution for claims and/or premiums paid for the ineligible dependent(s) will be pursued.

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 MTA-sponsored 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** Termination of Domestic Partnership Form (HR-BEN-065A) available on the My MTA Portal at www.mymta.info.

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

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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.

I understand that if my coverage is waived, I may subject myself and/or my dependents to a waiting period if I decide to enroll at a later date.

Employee/Retiree 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 spouse's *Birth Certificate*, either one (1) of the following official government documents can be alternatively submitted:
   - Government-issued Photo Identification (ID) Card
   - Valid US Passport

   AND

   If your date of marriage is more than one (1) year old as listed on your official governmental marriage certificate, proof of joint ownership is also required. If your marriage date is less than 1 year old, proof of joint ownership is not required.

   To ***remove*** a spouse from your MTA-sponsored coverage due to divorce, you **MUST** submit the first and last page of the divorce decree filed by the County Clerk's Office which shows the court filing date. You are **REQUIRED** to notify the MTA BSC of your legal divorce within thirty-one (31) days of the divorce date indicated on the divorce decree.

   Both the enrollee's and spouse's names must be listed on the documentation of joint ownership. Proof of joint ownership **MUST** be dated within the past 90 days. Examples of proof of joint ownership include a copy of:
   - Most recent federal or state 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.**