APPLICATION FOR RETIREMENT LEAVE OF ABSENCE (TRAVIA)

College: John Jay College of Criminal Justice

PSC-CUNY AGREEMENT SECTION 16.4: Persons who are member of a public retirement system and who meet the eligibility requirements for service retirement, and persons who are members of the optional retirement program and who meet similar eligibility requirements to those of the public retirement system, who announce their bona fide intention to retire and file the appropriate application to retire shall be granted a retirement leave of absence with full pay consisting of one-half of their accumulated unused temporary disability leave up to a maximum of one semester, or the equivalent of school days. The terms and conditions relating to the counting of such days, intervening vacation periods, cancellation of such leave, reinstatement to active service, etc., shall be governed by Section 3107 of the State Education Law.

You must file retirement papers directly with the retirement provider in order to receive your retirement benefit. Any delay will result in a delay in receipt of your first retirement check and could result in a delay in your access to retiree health benefit (if eligible).

ERS - you must file within 30-90 days; TIAA-CREF and TRS - you must file at least one day before the effective date.

Prior to submitting the form to your supervisor, please meet with the College Benefits Officer to discuss relevant retirement information. Please ensure that you have submitted your latest time sheet. Any temporary disability leave taken after the submission of the form must be reported promptly to the Office of Human Resources.

Name _____ Empl. ID _____ Date of birth _____

Title _____ Department _____

Retirement System: ☐ BERS ☐ NYCERS ☐ TRS ☐ TIAA-CREF ☐ OTHER Retirement System # _____

Type of Retirement: ☐ Service ☐ Disability

I hereby apply for a retirement leave of absence starting: Date _____

The probable date of retirement is Date _____

☐ I filed my retirement papers with the appropriate retirement system on Date _____ *Attach copy of the acknowledgement receipt*

☐ I intend to file my retirement papers with the appropriate retirement system on Date _____

- *CUNY is authorized, if necessary, to determine from the retirement system my eligibility to retire.*
- *The retirement system will consider the period of my retirement leave as active service for retirement purposes.*
- *I understand that any temporary disability leave taken before the date of approval of the retirement leave and the starting date of the leave may reduce the length of retirement leave.*
- *If I have 160 days of accrued temporary disability leave as teaching instructional staff, I am eligible for travia leave equal to one semester.*
- *If I have 160 days of accrued temporary disability leave as non-teaching instructional staff, including ECP, I am eligible for travia leave equal to five (5) months.*
- *If I have less than 160 days of accrued temporary disability leave, my retirement leave dates will be calculated as half of the number of accrued days.*
- *Any temporary disability leave donated to the Dedicated Sick Leave and Catastrophic Leave programs may reduce the number of days calculated for Travia Leave.*
- *If I am a member of the non-teaching instructional staff, I will have to use my accrued annual leave days before I begin my retirement leave. Specific dates of annual leave and retirement leave must be discussed with the Benefits Officer / Director of Human Resources.*
- *I have the option to return to full-time service the day after my retirement leave ends. For teaching instructional staff, it must conform to the first day of the semester.*
- *For teaching instructional staff, retirement leave counts towards service after a paid academic leave (Fellowship/Scholar Incentive Award).*
- *If otherwise eligible, I may apply for Social Security at the beginning of my retirement leave.*

Signature _____ Date _____

Department Chairperson or Unit Head Approval

☐ *I am aware of the proposed retirement leave of absence. I will report any temporary disability leave taken before the beginning of the leave promptly to the Office of Human Resources.*

Name _____ Signature _____ Date _____

Authorized Signatory (as designated by campus/unit)

Name _____ Signature _____ Date _____

Authorized Signatory (as designated by campus/unit)

Name _____ Signature _____ Date _____

Health Benefits Program
Retiree Application/Change Form

www.nyc.gov/olr

Submit completed form as follows:
1) Mail: NYC Health Benefits Program
22 Cortlandt Street, 12th Floor New York, NY 10007
2) Electronically: https://nycemployeebenefits.leapfile.net
3) Fax: (212) 306-7373

Please print all information clearly using a black or blue pen. See page 2 for instructions.

REASON(S) FOR SUBMISSION (Check one or more boxes. Enter change effective date, if appropriate.)

A.
- ☐ New Retiree Enrollment
- ☐ Disability Retirement
- ☐ Add Optional Benefits*
- ☐ Drop Optional Benefits*
- ☐ Accident Disability Retirement
- ☐ Waive Benefits
- ☐ Reinstatement Benefits

*Indicate effective date: / /

B. Change of:
- ☐ Spouse/Domestic Partner ☐ Add ☐ Drop
- ☐ Dependent Children ☐ Add ☐ Drop
- ☐ Change of Name (attach legal documents)

Former Name*: _____

*Indicate effective date: / /

C. Change of Health Plan Reason:
- ☐ Annual Fall Transfer Period*
- ☐ Retiree Once-in-A- Lifetime
- ☐ Move into/out of Health Plan Area**

**Indicate effective date: / /

*Transfer Period changes are effective January 1.

D. RETIREE INFORMATION

SOCIAL SECURITY NUMBER:	PENSION ID NUMBER:	DATE OF BIRTH:	GENDER (SEE REVERSE):	MARITAL STATUS:	DATE OF EVENT (MM/DD/YYYY):
		/ /	☐M ☐F ☐N ☐O	☐SINGLE ☐MARRIED ☐DIVORCED ☐DOMESTIC PARTNERSHIP ☐WIDOWED	/ /

LAST NAME:	FIRST NAME:	MI:

ADDRESS:	APT.:

CITY:	STATE:	ZIP CODE:

COUNTRY (IF OUTSIDE THE U.S.):	EMAIL ADDRESS:	MOBILE TELEPHONE NUMBER:	HOME TELEPHONE NUMBER:
		( ) -	( ) -

NAME OF CURRENT CITY HEALTH PLAN (IF CHANGING):	MBI NUMBER (FROM MEDICARE CARD):	Are you Medicare eligible? ☐Yes ☐No If YES, Please attach a copy of his/her Medicare card to this application	ATTACH COPY OF MEDICARE CARD

AGENCY IN WHICH RETIRED FROM:	NAME OF UNION OR WELFARE FUND:	PENSION SYSTEM/ANNUITY FUND* (CHECK ONE):
		☐BERS ☐FIRE ☐NYCERS ☐POLICE ☐TIAA ☐TRS *Members of the VDC Program are not eligible for retiree health benefits.

E. SPOUSE/DOMESTIC PARTNER - ONLY COMPLETE IF YOUR SPOUSE/DOMESTIC PARTNER IS TO BE COVERED. IF NOT, LEAVE BLANK.

LAST NAME (AS IT APPEARS ON YOUR MEDICARE CARD, IF APPLICABLE):		Is spouse/domestic partner employed by the City? ☐Yes ☐No (DOUBLE CITY COVERAGE NOT PERMITTED) If YES please indicate the name of the agency spouse is employed by in the space below.	
FIRST NAME (AS IT APPEARS ON YOUR MEDICARE CARD, IF APPLICABLE):	M.I.:	DATE OF BIRTH: / /	NAME OF CITY AGENCY:

SOCIAL SCURITY NUMBER:	MBI NUMBER (FROM MEDICARE CARD):	GENDER (SEE REVERSE):	Is spouse/domestic partner Medicare eligible? ☐Yes ☐No If YES, Please attach a copy of his/her Medicare card to this application	ATTACH COPY OF MEDICARE CARD
		☐M ☐F ☐N ☐O		

F. FAMILY INFORMATION (Attach a second form if necessary; dependent may not be covered under two NYC Health Plans.)

List all eligible dependent children. Indicate if you are adding or dropping coverage by checking the appropriate box below.

****Attach a copy of Medicare card if disabled dependent is Medicare eligible.**

DEPENDENT LAST NAME'S	DEPENDENT FIRST NAME'S	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER M/F/N/O	ADD COVERAGE	DROP COVERAGE	PERMAMENTLY DISABLED**
		/ /	- -		☐	☐	☐
		/ /	- -		☐	☐	☐
		/ /	- -		☐	☐	☐
		/ /	- -		☐	☐	☐
		/ /	- -		☐	☐	☐

Retain a copy for your records.

Instructions for Completing the Retiree Health Benefits Application/Change Form

Gender Categories:

M - Male/Man **F** - Female/Woman **N** - Non-binary (Not female/woman or male/man) **O** - Choose not to disclose

Section A: If you are a NEW retiree, you should only select from the following: Retirement, Disability Retirement, Accident Disability Retirement or Waive Benefits.

If you file the Retiree Health Benefits Application for continuation of coverage into retirement with your agency personnel office prior to retirement (ideally provide 6 to 8 weeks notice), coverage begins on the day of retirement for most retirees. Employees who had previously waived coverage can enroll in Retiree Health Benefits upon retirement. Retirees who wish to continue to waive City health benefits must complete a new Retiree Health Benefits Application selecting to Waive Benefits. The effective date of the reinstatement will be the date of retirement, or the first day of the month following the processing of the this application. An enrollment is considered late if an application is submitted more than 30 days after the event that made the retiree or dependent eligible. In cases of late enrollment, coverage will begin on the first day of the month following the processing of this application.

If you are already covered as a retiree, you should only select from the following: Drop/Add Optional Benefits, Waive Benefits (if you wish to cancel your City coverage) and Reinstatement (if you are requesting to reinstate your City coverage after having previously waived coverage).

Section B: Please complete this section if you are adding a spouse, domestic partner or dependent child(ren). Refer to the Dependent Eligibility Required Documentation on page 4 of this form or on our website, at nyc.gov/hbp, for a list of all dependent eligibility documentation requirements for health benefits coverage for dependents.

If you are dropping a spouse, domestic partner or dependent child(ren) please submit appropriate documentation, e.g., death certificate, divorce decree, termination of domestic partnership or court order.

If changing your name, please indicate your former name and provide documentation of name change.

Section C: Check Transfer Period if the change you are requesting (such as Adding Optional Benefits or Changing Plans) is being made during a Annual Fall Transfer Period. (Changes will be effective January 1st.)

Check Permanent Move Into/Out of Health Plan Area if you are requesting to change plans as a result of either moving out of the service area of your current plan, or if you are moving into the service area of another plan.

Check Retiree Once in a Lifetime if you are requesting to change plans or add optional benefits anytime other than a transfer period. (Note: You can only use this option after being retired for one full year.)

Section D: If you are enrolled in Medicare Parts A & B, you must attach a photocopy of your Medicare card.

Section E: If you are married or have a domestic partner, this section must be completed only if you are covering your spouse/domestic partner.

If your spouse/domestic partner is enrolled in health plan other than your City coverage or Medicare, you must indicate so.

If your spouse/domestic partner is enrolled in Medicare Parts A & B, you must attach a photocopy of his/her Medicare card.

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

Section F: List **ALL** eligible dependent children to be covered. If a dependent child is permanently disabled, and on Medicare, you must attach a photocopy of his/her Medicare card. Visit OLR's website at nyc.gov/hbp for health plan rate information.

Section G: Write the complete name of your current health plan or the plan you are selecting (see back of sheet). If you do not make an optional rider selection, you will be given basic coverage only.

Section H: Your signature is required in this section to enroll or effect the changes requested on this Form.

Section I: If you are a NEW retiree (even if you are waiving City coverage), your payroll/personnel office must complete this section. If you are newly retired from H+H, CUNY TIAA or an eligible MTA City title, you must submit the appropriate document for adding a dependent.

G. HEALTH PLAN ELECTION - FOR HEALTH PLAN INFORMATION AND RATES, VISIT NYC.GOV/HBP

Place an "X" in the box next to the plan you choose to join. Select only one plan: if more than one plan is selected, your transfer request will not be processed.

NON-MEDICARE PLANS		*MEDICARE SUPPLEMENTAL PLANS*
☐ Aetna EPO	☐ GHI HMO	☐ DC 37 Med-Team Senior Care
☐ Cigna Healthcare	☐ HIP Prime HMO	☐ Empire Medicare-Related Coverage
☐ DC 37 Med-Team (DC 37 members only)	☐ HIP Prime POS	☐ GHI/EBCBS Senior Care
☐ Empire EPO	☐ MetroPlus Gold	☐ GHI HMO Medicare Senior Supplement
☐ Empire Gated EPO	☐ Vytra Health Plans	
☐ GHI-CBP/Empire BlueCross BlueShield		

Optional Rider Benefits? (Check "Yes" or "No" for optional rider benefits rider. If no box is checked, it will be presumed that you do not want optional rider benefits.)
☐ Yes ☐ No

MEDICARE HMOS & ADVANTAGE PLANS - YOU MUST HAVE MEDICARE PARTS A & B
(Contact the health plan directly for a special Medicare HMO Enrollment Form- the form must be returned directly to the health plan.)

Place an "x" in the box next to the plan you choose to join. You must complete and submit this form, as well as contact the Medicare HMO directly, to request a special enrollment form. The special enrollment form must be returned directly to the health plan. (If you are presently enrolled in a Medicare HMO and are transferring to a Medicare Supplemental Plan, you must first disenroll from your current plan.) Please also attach a copy of the special enrollment or disenrollment form to this application.

☐ AvMed Medicare Plan ☐ Aetna Medicare PPO Plan ☐ Cigna HealthSpring ☐ Elderplan ☐ Empire MediBlue
☐ Humana Gold Plus ☐ HIPVIP Premier Medicare Plan ☐ United HealthCare Group Medicare Advantage Plan

H. TO PARTICIPATE IN THE HEALTH BENEFITS PROGRAM OR REQUEST CHANGES TO HEALTH COVERAGE

I certify that the above information is correct and I authorize the City to deduct from my pension the amount required, if any, through the City Health Benefits Program.

I understand that the City Program's benefits will be coordinated with those available through Medicare or any other source.

If I have checked the Waive Benefits Box in Section A, I am choosing not to participate in the City Health Benefits Program at this time.

Retiree's Signature: _____ Date: _____

I. FOR COMPLETION BY PAYROLL OR PERSONNEL OFFICE ONLY

I certify that the above retiree is eligible for the New York City Health Benefits Program (HBP) and that dependent documentation has been verified in accordance with HBP procedures.

AGENCY CODE:	TITLE CODE:	STATUS: ☐ FULL-TIME ☐ PART-TIME	RETIREMENT DATE: / /	EFFECTIVE DATTE OF COVERAGE: / /	
PENSION SYSTEM:		YEARS OF CREDITED SERVICE:	CITY START DATE: / /	PENSION NUMBER:	
CERTIFYING SIGNATURE:				DATE: / /	TELEPHONE NUMBER: ( ) -

Dependent Eligibility Required Documentation

Below is a list of all dependent eligibility documentation requirements for health benefits coverage for adding dependents.

For a Spouse

- married one year or less – Government Issued Marriage Certificate
- married more than one year – Government Issued Marriage Certificate and one of the following:
  - Federal tax return filed within last two years and listing spouse as joint or individual
  - Proof of joint ownership (bank account, auto, home, etc.) issued within last six months
  - Proof of cohabitation (two separate documents – one in your name and one in your spouse's name – at the same address, such as utility bills, bank statements or credit card statements)

For a Domestic Partner

- partnership of one year or less – Domestic Partnership Certificate of Registration
- partnership of more than one year – Domestic Partnership Certificate of Registration and one of the following:
  - Proof of joint ownership (bank account, auto, home, etc.) issued within last six months
  - Proof of cohabitation (two separate documents – one in your name and one in your domestic partner's name – at the same address, such as utility bills, bank statements or credit card statements)

For a Child

NOTE: Disabled status for any child still requires current medical certification from the health plan in addition to the documents listed below.

- Biological Child
  - Government Issued Birth Certificate (including parent's names)

- Step Child – Must be spouse's child. One of the following combinations of documents is required:
  - Government Issued Birth Certificate (including parent's names) and Government Issued Marriage Certificate if married one year or less
  - Government Issued Birth Certificate (including parent's names) and Government Issued Marriage Certificate and Federal tax return filed within last two years listing spouse as joint or individual
  - Government Issued Birth Certificate (including parent's names) and Government Issued Marriage Certificate and proof of joint ownership (bank account, auto, home, etc.) issued within last six months

- Domestic Partner's child – Must be registered domestic partner's child. One of the following combinations of documents is required:
  - Government Issued Birth Certificate (including parent's names) and Domestic Partnership Certificate of Registration if partnership of one year or less
  - Government Issued Birth Certificate (including parent's names) and Domestic Partnership Certificate of Registration and proof of joint ownership (bank account, auto, home, etc.) issued within last six months

- Legal Ward
  - Government Issued Birth Certificate and the court ordered document of legal custody

- Tax Dependent Child
  - Government Issued Birth Certificate and the federal tax return filed in the previous year listing child as dependent

Health Plans Available to
Employees, Non-Medicare Retirees and their Dependents

Aetna EPO
Cigna HealthCare
DC 37 Med-Team (DC 37 members only)
Empire EPO
Empire HMO
GHI-CBP/Empire BlueCross BlueShield
GHI HMO
HIP Prime HMO
HIP Prime POS
MetroPlus Gold
Vytra Health Plans

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

Health Plans Available to
Medicare-Eligible Retirees and their Dependents

Aetna Medicare PPO ESA Plan*
AvMed Medicare HMO* (Florida only)
Cigna HealthSpring Preferred with Rx (HMO)* (Arizona only)
DC 37 Med-Team Senior Plan (DC 37 Members Only)
Elderplan*
Empire Medicare Related Coverage
Empire MediBlue HMO*
GHI/Empire BlueCross BlueShield Senior Care
GHI HMO Medicare Senior Supplement
HIP VIP Premier (HMO) Medicare Plan*
Humana Gold Plus (certain counties in Florida)*
UnitedHealthcare Group Medicare Advantage Plan*

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

* Medicare eligible retirees who wish to enroll in these plans must enroll DIRECTLY with the health plan. Please verify with the health plan of your choice whether or not you reside in its service area. Do not use this form for enrollment in these plans.

Retiree Enrollment Form

PSC-CUNY Welfare Fund
61 Broadway, 15th Floor
New York, NY 10006
Office: 212-354-5230 Fax: 212-354-5363
Website: www.psccunywf.org

Required

A copy of your NYC Health Benefits Application is required. WF Domestic Partner form if Applicable.

If Medicare Eligible, include a copy of your Medicare Card for you and/or your dependent.

If Member/Dependent is eligible for PSC-CUNY WF Med D Plan, include CVS SilverScripts Enrollment Forms.

Member

Retirement Date: ____/____/____ Pension ☐ TRS ☐ ERS ☐ TIAA

Social Security: _____ Medicare ID # _____ DOB: ____/____/____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Marital Status: ☐ S ☐ M ☐ DP Gender: ☐ F ☐ M

Primary Telephone: (____) _____ Primary Email: _____

Spouse Domestic Partner

Social Security: _____ Medicare ID # _____ DOB: ____/____/____

First Name: _____ Last Name: _____

Covered by other NYC Plan _____ *Welfare Fund* Covered by private Health Plan _____ *Name of Plan*

Dependents

SSN	Name	DOB	Gender	Status (child,disabled)

Dental

For previously Deferred Members Only. For more information visit: www.psccunywf.org

☐ Guardian ☐ *DeltaCare USA **Delta will assign you a Dentist. To change it, call Delta or go Online.*

Insurance

Health Plan _____ Basic ☐ Rider ☐ Waive All Benefits ☐

Member

I hereby certify that all of my personal information presented here is true and accurate.

Signature _____ Date _____

College

I hereby certify to the best of my knowledge that the information presented here is accurate, complete and sufficient to verify eligibility for benefits under the PSC-CUNY Welfare Fund.

Benefits Officer _____ College _____ Date _____

[PSC-CUNY Welfare Fund Use Only] [Alpha]

Date Received Authorization Initials Date

RETIREE E-MAIL

College: John Jay College of Criminal Justice

At the June 2015 Board meeting, an amendment to the CUNY Policy on Acceptable Use of Computer Resources was approved that allows teaching faculty and librarians the option to retain their current CUNY e-mail address upon retirement. *Faculty counselors also have the option to retain their current CUNY e-mail address upon retirement.*

Employees, such as those in the Executive Compensation Plan and non-teaching instructional staff titles such as Higher Education Officer series, College Laboratory Technician series, Research Associates and Research Assistants will be given a one-time option at the time of retirement (during the off-boarding/exit interview process), to request a "retiree" e-mail. *(Teaching faculty, librarians and faculty counselors may also opt for a "retiree email", in lieu of retaining their current email address, if they so choose.)*

Under rare and unique circumstances, the college president or in the case of the Central Office, the Chancellor or his/her designee, may approve the retention of the current CUNY e-mail address for these titles.

CUNY e-mail addresses are not available to employees who resign, or are non-reappointed or otherwise terminated.

The Office of Human Resources is advised to retain this form, along with the off-boarding/exit interview form for the employee.

Employee/Retiree Information:

Name _____ Empl. ID _____

Contract Title _____ Department _____

Retirement Date _____ *NOTE: During travia leave, the employee retains his/her current e-mail.*

☐ **I request to continue my current e-mail address.**

Attestation by Employee/Retiree:
- I acknowledge that I am not an active employee of the college/University Management, as noted above
- I agree not to hold myself out as an active employee of the college/University Management, as noted above
- I acknowledge receipt of the CUNY Policy on Acceptable Use of Computer Resources
- I will comply with the University's policies and procedures regarding electronic communications, including, but not limited to, the University's Policy on Acceptable Use of Computer Resources, to the extent applicable
- I acknowledge that I will not have access to groups and shared mailboxes used to conduct University/College business

☐ **I request a retiree e-mail address (".ret")** I should be notified at this e-mail address when the retiree e-mail is created _____

Attestation by Employee/Retiree:
- I acknowledge that I am not an active employee of the college/University Management, as noted above
- I agree not to hold myself out as an active employee of the college/University Management, as noted above
- I acknowledge receipt of the CUNY Policy on Acceptable Use of Computer Resources
- I will comply with the University's policies and procedures regarding electronic communications, including, but not limited to, the University's Policy on Acceptable Use of Computer Resources, to the extent applicable
- I acknowledge that if my retiree account is inactive for more than 12 calendar months (one year), the University will inactivate my account

☐ **The College President/Chancellor or his/her designee has approved the retention of my current e-mail address.** ***(HR must attach appropriate approval)***

Attestation by Employee/Retiree:
- I acknowledge that I am not an active employee of the college/University Management, as noted above
- I agree not to hold myself out as an active employee of the college/University Management, as noted above
- I acknowledge receipt of the CUNY Policy on Acceptable Use of Computer Resources and I will comply with the University's policies and procedures regarding electronic communications, including, but not limited to, the University's Policy on Acceptable Use of Computer Resources, to the extent applicable
- I acknowledge that I will not have access to groups and shared mailboxes used to conduct University/College business, unless specifically approved by the President/Chancellor or his/her designee

Signature _____ Date _____

RECEIVED BY (This form must be signed by the Director of Human Resources or Designee)

Signature _____ Date _____

University Benefits Office
395 Hudson Street – 5th Floor
New York, NY 10019
Tel: 646-664-3352
Fax: 646-664-3418

November 14, 2019

RE: TIAA Lifetime Income Annuity

Dear CUNY Retiree:

Our records indicate you are eligible for retiree health benefits provided by the New York City Health Benefits Program (NYCHBP). You must complete an Employee Health Benefits Application (ERB) and submit it to your College Benefits Officer.

Additionally, you must set up a Lifetime Income Annuity with TIAA, to generate a monthly stream of income from which deductions for health insurance premiums will be withheld. Contact TIAA at 1-800-842-2776 to start a monthly ***Lifetime Income Annuity***, on a minimum of $10,000, from your $50,000 required reserve, to satisfy standard health care premium deductions. More costly plans may require additional amounts to be annuitized. When consulting with the TIAA Representative make sure to inform them of the monthly health insurance premium for the carrier you selected. This will ensure you annuitize the appropriate amount to cover the monthly premium.

Your monthly Lifetime Income Annuity must be set up prior to enrolling in health benefits. You must submit a copy of the Confirmation for Annuity Payment from TIAA to your College Benefits Officer to initiate the health insurance enrollment process. Failure to set up a monthly Lifetime Income Annuity may jeopardize your health insurance enrollment.

Please note that Interest Only, Minimum Distribution, and Transfer Payout Annuities are not considered settlement options used to satisfy your health care premium deductions.

If you are or will be age 65, you may be eligible for Medicare Part B Premium Reimbursement. In addition to completing an ERB and starting a monthly Lifetime Income Annuity, you must complete an application for Medicare Part B Premium Reimbursement. Furthermore, your spouse or domestic partner may also be eligible for Medicare Part B Premium Reimbursement. Applications are available at your College Human Resources Office.

Sincerely,

Matthew Manfredi

Executive Director of University Benefits

UBO USE ONLY

RET/TERM:_____ 1ST Payment Year: _____

EE Med Part B:_____ PYC's:_____

SP/DP Med Part B: _____

(MEMBERS OF TIAA-CREF PENSION SYSTEM)
APPLICATION FOR MEDICARE PART B PREMIUM REIMBURSEMENT

RETIREE INFORMATION

RETIREE INFORMATION: Social Security Number:_____-_____-_____

Name: _____ Date of Birth:_____

Address:_____ Apt. No _____

City _____ State _____ Zip Code _____

Email Address:_____ Telephone No. (_____) _____

College Retired From:_____ Retirement Date:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner Date of Event:_____

Do you receive a monthly Lifetime Income Annuity from TIAA? ☐ Yes ☐ No

Are health insurance premiums withheld from your TIAA pension check? ☐ Yes ☐ No ☐ No Premium Required

Current New York City Retiree Health Plan: ☐ Individual ☐ Family Plan

ATTACH COPY OF YOUR RETIREE HEALTH INSURANCE CARD AND THE SIGNED MEDICARE CARD FOR YOURSELF AND YOUR ELIGIBLE DEPENDENT(S).

DEPENDENT INFORMATION

SPOUSE/DOMESTIC PARTNER INFORMATION: Social Security Number:_____-_____-_____

Name: _____ Date of Birth:_____

Is spouse/Domestic Partner employed or retired from a NYC agency? ☐ Yes ☐ No

Is spouse/Domestic Partner covered on retiree's health plan? ☐ Yes ☐ No

Spouse/Domestic Partner's employment status: ☐ Not Employed ☐ Retired ☐ Employed

Is spouse/Domestic Partner receiving Medicare Part B premium reimbursement through their employer? ☐ Yes ☐ No

MEDICARE INFORMATION: Medicare Claim Number _____ Effective Date Part-A _____ Effective Date Part B _____

ADDITIONAL INFORMATION

DISABLED DEPENDENT (CHILDREN) INFORMATION: Social Security Number:_____-_____-_____

Name: _____ Date of Birth:_____

Medicare Claim#:_____ Effective Date Part A:_____ Effective Date Part B: _____

BENEFICIARY INFORMATION (*Refer to application instructions for description of beneficiary***):**

Name:_____ Telephone No. (_____) _____

Address:_____ Apt. No. _____

City _____ State _____ Zip Code _____

AFFIRMATION:

Your signature below affirms that you have provided accurate information; that you authorize the Social Security Administration to furnish information relative to your Medicare enrollment; that you understand that information supplied may be used by the City to appropriately adjust your Health Insurance.

Signature of Retiree:_____ Date:_____

Signature of Spouse/Domestic Partner:_____ Date:_____

INSTRUCTIONS
Application for Medicare Part B Premium Reimbursement
(Members of TIAA Pension System)

A. ELIGIBILITY

During those months for which a reimbursement is requested, the retiree must have been:

1. Receiving a monthly Lifetime Income Annuity from TIAA to satisfy standard health care premium deductions (Interest Only, Minimum Distribution and Transfer Pay Out Annuity are not considered settlement options used to satisfy your health care premium deductions); and
2. Enrolled in and paying premiums for a New York City Health Benefits Plan as the contract holder (premiums must be deducted from your monthly TIAA pension check); and
3. Enrolled in and paying premiums for Medicare Medical Insurance (Part B), and
4. Your primary residence is within the United States.

B. SPOUSE/DOMESTIC PARTNER OR DISABLED CHILDREN OF RETIREE

If a spouse/domestic partner or a disabled dependent is enrolled in Medicare Part B and is covered under an eligible retiree's New York City health plan, Medicare premiums may be reimbursed to the retiree. An application for reimbursement must be completed when adding a spouse/domestic partner and/or disabled child.

C. HEALTH INSURANCE COVERAGE FOR DISABLED DEPENDENTCHILDREN

Unmarried children age 26 and older who cannot support themselves because of a disability, including mental illness, developmental disability, mental retardation or physical handicap are eligible for coverage if the disability occurred before the age at which the dependent coverage would otherwise terminate. You must provide medical evidence of the disability.

D. SURVIVORS OF RETIREES

Unless a survivor is retired from The City University or a New York City agency, and is eligible for and enrolls in the New York City Health Insurance Program as the contract holder, he/she is not eligible for reimbursement for any month beyond the period of the deceased retiree's eligibility. As a reminder, health insurance benefits for survivors of retirees ceases with the death of the retiree, however, survivor dependents may be eligible for continuation of coverage under COBRA. Also, refer to the PSC-CUNY Welfare Fund website http://www.psccunywf.org for information on continuation of coverage under COBRA for supplemental benefits.

E. GENERAL INFORMATION

- The City of New York Office of Labor Relations (OLR) – Health Benefits Program processes Medicare Part B reimbursements annually, usually in August, for the previous year at the standard monthly rate. The first payment year will be the year **after** your retirement date, provided you are Medicare-eligible; or the year **after** you become Medicare-eligible. You ***do not need to apply annually*** for this benefit.
- IRMAA – If you and eligible dependents pay more than the standard monthly rate, you ***must apply annually*** directly through OLR to obtain full reimbursement of Medicare Part B premiums. Claims must be submitted to OLR following receipt of the standard monthly premium reimbursement. Forms and information regarding IRMAA can be found at: http://www.nyc.gov/html/olr/html/health/health_benefits_prog.shtml.
- Your Medicare Reimbursement check will be mailed to the address that appears on your application. Please notify this office of your change in address by completing a Change of Address form. Forms can be obtained by contacting Office of Human Resources Management at 646.664.3409. You do not need to apply for reimbursement each year, however, periodically we will mail out a recertification form requesting you review and update your personal information.
- Medicare does not pay for hospital or other medical expenses outside the U.S. If you plan to travel abroad, consider obtaining additional insurance. Currently, the Health Benefits Program does not process reimbursement for retirees residing outside the US territory.
- The University Benefits Office should be notified of any changes due to death of the retiree, spouse/domestic partner or dependent, changes in marital status or any other change which may impact payment of reimbursement for premiums of Medicare Part B.
- A beneficiary is a person, other than yourself, who has been designated by you, to be the administrator or executor of your estate. This beneficiary will be notified of any final Medicare Part B Premium reimbursement upon your death. However, if your spouse/domestic partner is covered as a dependent under your New York City health plan, final payments will be paid to your spouse/domestic partner. To obtain any final payments your beneficiary or surviving spouse/domestic partner must complete and submit a notarized Affidavit, along with a copy of the death certificate and a copy of the will or court document indicating who is the sole beneficiary, the executor/executrix or the administrator/administratix of your Estate.

Office of Human Resources Management.
University Benefits Office: 395 Hudson Street, 5th Floor, New York, NY 10014

New York City Office of Labor Relations
Health Benefits Program
nyc.gov/olr

HBP

Notification of Your Medicare Part B Enrollment Application

Complete this application to notify the Health Benefits Program that you have enrolled in Medicare Part B. **Attach a copy of your Medicare card to this application.** Once you submit this application, you will be enrolled in the Medicare Part B Reimbursement Program and will **not** have to resubmit an application every year.

Medicare Part B Reimbursement Program: The City of New York Health Benefits Program reimburses Medicare-eligible retirees and their Medicare-eligible dependents for any Medicare Part B premiums (excluding any penalties) paid during the calendar year, as long as the following conditions are met:

1. The Medicare-eligible retiree is receiving a pension from a City of New York pension system, and
2. The Medicare-eligible retiree and/or Medicare-eligible dependent(s) is covered under a City of New York health plan, and
3. The health plan has the Medicare-eligible retiree and/or Medicare-eligible dependent(s) in Medicare status, and
4. The retiree is currently paying Medicare Part B premiums and is not receiving Medicare Part B reimbursement(s) from any other source including Medicaid.

Reimbursement will be issued to you in the same manner in which you receive your pension payments; if you receive direct deposit of your pension payments, your reimbursement will also be made via direct deposit.

Reimbursement will occur in the spring of the year, following the close of the year in which you paid Medicare Part B premiums. For example, any Medicare Part B premiums you paid in 2019, would be reimbursed to you in Spring 2020.

Section I: Retiree Information: YOU MUST PROVIDE A COPY OF YOUR MEDICARE CARD

Name (Last, First, MI): _____ Social Security Number: _____

Retirement Date: _____ Pension System: _____ Pension No.: _____

Health Plan Name: _____ Union/Welfare Fund: _____

Date of Birth: _____ Address: _____

Phone Number: _____ _____
City State Zip

Section II: Eligible Dependent Information: YOU MUST PROVIDE A COPY OF YOUR DEPENDENT'S MEDICARE CARD

1) Name (Last, First, MI): _____ Social Security Number: _____

Date of Birth: _____ Address: _____

Phone Number: _____ _____
City State Zip

2) Name (Last, First, MI): _____ Social Security Number: _____

Date of Birth: _____ Address: _____

Phone Number: _____ _____
City State Zip

*Please submit this form, along with a **copy of applicable Medicare Card(s)***

Electronically to:
https://nycemployeebenefits.leapfile.net

OR

By mail to:
NYC Health Benefits Program
Attn: Medicare Unit
22 Cortlandt Street, 12th Floor
New York, NY 10007

Please note: Queens Borough Public Library retirees, Brooklyn Public Library retirees, and City University of New York retirees should contact their agency's benefits office directly. Retired NYCTA civilians, with the exception of NYCTA Police Officers, must contact the Transit Authority.

Furthermore, the Medicare Part B/IRMMA reimbursement by the City of the Medicare Part B premiums actually paid to Medicare by retirees, pursuant to Section 12-126 of the New York City Administrative Code, are excludable from the gross income of the retiree under Section 106 of the Internal Revenue Code.

Print Form Clear Fields

Office of Human Resources Management
Shared Services - University Benefits Office
555 West 57th Street, 11th Floor
New York, NY 10019
Tel: 646-313-8231
Fax: 646-313-8888

RETIREE CHANGE OF ADDRESS FORM

Note: This form is to ONLY be used for updating your address NOT to transfer plans or add/drop dependents/optional riders. A change of address may necessitate a change of health plans. Please check with your plan to see if your NEW address is within their service area. If you need to change health plans as a result of your new address, you must contact:

- If you are a TIAA-CREF member - The University Benefits Office
- If you are a TRS or NYCERS member - The Office of Labor Relations Employee Benefits Program

Name: _____ Social Security Number: xxx-xx- ☐☐☐☐

Email Address: _____

College Retired from: _____ Retirement date: _____

Pension System (Circle One): TIAA-CREF TRS NYCERS

NEW ADDRESS:

_____
Number and Street Apt. Number

_____ Telephone Number: (___)_____
City State Zip Code

OLD ADDRESS:

_____
Number and Street Apt. Number

_____
City State Zip Code

The completed change of address form must be returned to the University Benefits Office at the address above.

You must notify NYC Office of Labor Relations (OLR), PSC-CUNY Welfare Fund, and your pension system (either TIAA-CREF, TRS and/or NYCERS) of you change of address.

NYC Office of Labor Relations 40 Rector Street, 3rd Floor New York, NY 10006 (212) 306-7200 Fax (212) 306-7756 HB Unit	PSC-CUNY Welfare Fund 61 Broadway, 15th Floor New York, NY 10006 (212) 354-5230	TIAA-CREF or 730 Third Avenue New York, NY 10017 (800) 842-2252	TRS or 55 Water Street New York, NY 10014 (888) 869-2877	NYCERS 335 Adams Street, Ste 2300 Brooklyn, NY 11201-3724 (347) 643-3000 (877) 669-2377 (outside NYC)

Retiree Signature _____ Date _____

\f\forms\address change 070913

UBO Use Only: Sent copy to College Benefits Officer _____ Entered in Medicare Part B File _____