2024 Open Enrollment/Change Form

For Active NYCT ATU Local 726 Employees

HR-BEN-810B

Section 1 - Information and Instructions

Complete this form to enroll in **or** change your health insurance coverage. This form is only for Active NYCT ATU Local 726 employees and/or their dependent(s). Do **NOT** submit this form if you are making your plan enrollment changes online.

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 may be submitted via fax to 212-852-8700 **OR** via email to BSC-Benefits@mtabsc.org.

If you have questions, contact the Business Service Center (BSC) at 646-376-0123, 8:30AM - 5:00PM, Monday to Friday **OR** BSC-Benefits@mtabsc.org.

Section 2 - Employee Information

Print Name	Last	First	M.I.	BSC ID#
Phone (Cell)		Phone (Home)		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 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 and Dental Coverage Election (Effective January 1, 2024)

MEDICAL: Individual ☐ Family ☐

Check only **ONE**:

☐ **AETNA CPOS II BASIC OPTION**

☐ **AETNA CPOS II HIGH OPTION** (Includes EmblemHealth Preferred Dental Coverage | Bi-weekly, pre-tax required contribution of $13.17 for Individual Coverage and $26.34 for Family Coverage)

☐ **AETNA SELECT OPTION** (National provider network allows you to see Aetna participating providers within the United States)

MTA MEDICAL OPT-OUT PROGRAM

☐ **I WISH TO ENROLL IN THE MTA MEDICAL OPT-OUT PROGRAM FOR MEDICAL, HOSPITAL, AND PRESCRIPTION DRUG COVERAGE**

I agree to the terms and conditions of the Medical Opt-Out Program detailed in Section 7 of this form. Proof of alternate medical enrollment **MUST** be provided below.

Name of Policyholder: _____

Employer of Policyholder: _____

Name of Insurance Carrier: _____

Policy Number: _____

Relationship to Policyholder: _____

Date of Birth of Policyholder: _____

SSN of Policyholder: _____

Section 4 - Dependent Information

ADD, REMOVE, OR CHANGE DEPENDENT(S):

Please fill in all information for dependents you wish to add (enroll), remove (delete), or change, and submit the required documentation (see Section 6 of this form). Use a separate sheet if more space is needed. Failure to submit required documentation will result in your request **NOT** being processed.

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 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 open enrollment/change form along with the Termination of Domestic Partnership Form.

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

Section 5 - Signature and 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 dependent children from age 19 to 26 I have enrolled are eligible for MTA-sponsored coverage.

Employee Signature:	**Date:**

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Section 6 - Required Supporting Documentation

1. **For a Spouse:**
   A copy of your Marriage Certificate, Birth Certificate, and 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 showing the court filing date.**

   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*

   If you are not able to provide the required documentation, please complete the Employee/Retiree Affidavit, have it notarized, and return it with your completed enrollment form.

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.**

Section 7 - MTA Medical Opt-Out Program Terms and Conditions

MTA MEDICAL OPT-OUT PROGRAM INCENTIVE:
You may opt-out of medical coverage and receive a lump-sum incentive payment. Opting out of medical coverage means that you elect *not* to participate in MTA-sponsored **medical, hospital, and prescription drug coverage**. You will however retain coverage in the dental and vision plans as applicable.

If you participate in the opt-out program and separate from MTA service *before* the end of the opt-out year, you will **not** be eligible to receive any part of the incentive payment. To be eligible for the opt-out program, you **must** document you will be covered by another medical plan sponsored by:
- A spouse or domestic partner's employer
- Another employer
- The Armed Forces

LUMP-SUM INCENTIVE PAYMENT:
Payment of the lump-sum incentive will be made at the *end* of the opt-out year as indicated below:
- **$550** for employees receiving medical coverage via a spouse/domestic partner also employed by NYCT or another MTA agency
- **$550** for employees who opt out of *INDIVIDUAL* medical coverage
- **$1,100** for employees who opt out of *FAMILY* medical coverage

TERMS OF AGREEMENT:
I understand this election will be effective from January 1 - December 31, 2024, unless I am no longer allowed by law or as a result of a qualifying event or such other events as the Authority determines will permit a change or revocation of an election. I understand the lump-sum payment will be subject to all applicable federal, state, and local taxes. I also understand that these monies will *not* be considered income for pension purposes and will *not* be included in any calculation therein. This agreement is subject to the terms of the employer's plan in effect and as amended from time to time and shall be governed by and construed in accordance with applicable laws. This agreement shall take effect as a sealed instrument under applicable laws and revokes any prior election and compensation agreement relating to such plan. The health benefits waiver (opt-out) will be administered as permissible under IRS Section 125.