

ERB/ERB2000 Health Benefits Application Checklist - Employees

All employees who are payrolled under non-H/ZBank titles will complete a Health Benefits Application (ERB) in order to enroll in a benefits plan (new hires). Additionally, this form is used by all employees, including H/ZBank titles (if the customized NYCAPS health benefits enrollment form has not been requested), to make any changes to their current enrollment (existing employees).

It is important to remember that different sections are related and many fields are required. Additionally, you must always remember to submit PHOTOCOPIES of the appropriate supporting documentation for any and all dependents and qualifying events.

Section A: Reason(s) for Submission

This section identifies your status and the reason you are submitting the application.

1. Select EITHER **Employee** or **Retiree** using the checkboxes at the top of the form, above Section A.
2. Select a reason for submission in Section A. The value selected here will determine the next section that is required.
3. Select from below.
 - New Enrollment
 1. Proceed to [Section D](#).
 - Reinstatement
 1. Reinstatements are valid only if you are being rehired within a year of their separation from service OR returning from a leave. Outside of these conditions, "New enrollment" must be selected.
 2. Confirm your payroll secretary or HR representative has submitted a 1054 form for the reinstatement.
 3. Proceed to [Section D](#), unless you are also electing to add or drop a dependent. If you are adding/dropping a dependent, proceed to [Section C](#).
 - Transfer from another agency
 1. Proceed to [Section D](#), unless you are also electing to add or drop a dependent. If you are adding/dropping a dependent, proceed to [Section C](#).
 - Retirement
 1. Work with your retirement system (TRS, BERS, etc.) to obtain a receipt confirming your eligibility for retiree benefits. You will need to provide this receipt along with the ERB form in order to enroll in retiree benefits.

2. Proceed to [Section D](#).
- Disability Retirement
 1. Work with your retirement system (TRS, BERS, etc.) to obtain a receipt confirming your eligibility for retiree benefits. You will need to provide this receipt along with the ERB form in order to enroll in retiree benefits.
 2. Proceed to [Section D](#).
 - Accident Disability Retirement
 1. Work with your retirement system (TRS, BERS, etc.) to obtain a receipt confirming your eligibility for retiree benefits. You will need to provide this receipt along with the ERB form in order to enroll in retiree benefits.
 2. Proceed to [Section D](#).
 - Deferred Retirement
 1. Contact OLR about deferred retirements before submitting the ERB to DOE.
 - Drop Optional Benefits

IMPORTANT: Optional benefits ("riders") can be dropped ONLY during the transfer period, as a result of a title change that impacts your benefits (for example, moving into our out of a union title), or as a result of an approved City hardship. Confirm that one of these conditions is met before selecting this option.

 1. Proceed to [Section B](#).
 - Add Optional Benefits

IMPORTANT: Optional benefits ("riders") can be added ONLY during the transfer period, as a result of a title change that impacts your benefits (for example, moving into our out of a union title), or as a result of an approved City hardship. Confirm that one of these conditions is met before selecting this option.

 1. Proceed to [Section B](#).
 - Waive Benefits
 1. Proceed to [Section D](#).
 - Buy-out Waiver Program (Employees Only)
 1. Ensure that you have obtained and completed the Medical Spending Conversion (MSC) Health Benefits Buy-out Waiver Program form for the CORRECT plan year. This form must be included with your completed ERB in order to enroll in the buy-out waiver program. In addition, you must provide the appropriate supporting documentation (e.g. a copy of your non-City insurance card for enrolling in the program, or a letter of benefits termination from your non-City carrier or employer for withdrawing from the program).

2. Proceed to [Section D](#), unless you are also electing to add or drop a dependent. If you are adding/dropping a dependent, proceed to [Section C](#).
- Other
 1. Specify the reason you are submitting the form in the space provided.
 2. Proceed to [Section B](#).

Section B: Reason(s) For Submission

This section is specific to employees who are CHANGING an existing enrollment, and is only completed if you selected "Drop Optional Benefits," "Add Optional Benefits," or "Other" in [Section A](#).

1. Select the reason for changing your enrollment.
2. Select from below.
 - Transfer Period
 1. Confirm that you are submitting the application during the annual Open Enrollment (transfer period). The transfer period typically occurs between mid-October and mid-November.
 2. Select from below.
 - Submitting the form OUTSIDE of the transfer period
 1. Employees may not change their health care provider outside of the designated annual health benefits transfer period, unless moving into or out of a union title, or in very rare cases for financial or medical hardships. If you feel you have a financial or medical hardship that requires an exception, write a letter that includes your name, Employee ID/File Number, Social Security number, and detailed explanation of the hardship, and mail the letter to:

HR Connect Health Benefits Administration
65 Court St., Room 101
Brooklyn, NY 11201
 - Submitting the form DURING the transfer period
 1. Proceed to [Section C](#).
 - Permanent Move Into/Out of Health Plan Area
 1. Ensure that you have already submitted your personal data change (PDC) for the address change to HR Connect. You may choose to do this in person at the HR Connect Walk-in Center at 65 Court Street in Brooklyn, or you may call HR Connect at 718-935-4000 to make the change over the phone.
 2. Write the effective date of your move in the correct format (MM/DD/YY) in the space provided.
 3. Proceed to [Section C](#).

- Retiree Once In A Lifetime
 1. Work directly with OLR to make the retiree once-in-a-lifetime elections change. DOE does not administer changes to existing retiree benefits elections.
- Other
 1. Specify the reason in the space provided.
 2. Proceed to [Section C](#).

Section C: Reason(s) For Submission

This section is specific to employees who have a family status or name change. New enrollments do not need to complete this section.

1. Select the appropriate type of family status or name change.
2. Select from below.
 - Spouse/Domestic Partner Information
 1. Select "Add" or "Drop."
 2. Specify the date of the qualifying event in the correct format (MM/DD/YY).
 3. Proceed to [Section D](#).
 - Dependent Child(ren)
 1. Select "Add" or "Drop."
Note: Dependent "drops" should only be submitted during the annual health benefits transfer period.
 2. Specify the date of the qualifying event in the correct format (MM/DD/YY).
 3. Proceed to [Section D](#).
 - Change of Name - Former Name

NOTE: You do not need to submit a separate ERB simply to change your name on your benefits. This field is intended for you to indicate your former name, if your name is changing due to a qualifying event (such as marriage or divorce).

 1. Specify your PREVIOUS name in the space provided.
 2. If you have not already done so, submit a personal data change (PDC) form for the name change with HR Connect. This form can be obtained from the DOE website at schools.nyc.gov/DHRForms. You will need to submit a PHOTOCOPY of your updated Social Security card with this form in order to update non-benefits systems at DOE. For more information on how and where to submit this form, please call HR Connect at 718-935-4000.

3. Provide a PHOTOCOPY of a legal document that displays your new name. Examples of appropriate supporting documentation include: Social Security card, passport, driver's license, state photo ID, etc. It is important to note that this supporting documentation is **in addition** to the PDC form and Social Security card you need in order to update other DOE systems described above.
 4. Proceed to [Section D](#).
- Other
 1. Specify the reason in the space provided.
 2. Proceed to [Section D](#).

Section D: Employee/Retiree Information

This section contains the employee's personal information. This section must ALWAYS be complete in order to process the enrollment form. Unless otherwise indicated, all the information described below must be provided.

1. Specify your LEGAL last name in the "Last Name" field.
2. Specify your LEGAL first name in the "First Name" field.
3. Specify your middle initial (if applicable) in the "M.I." field.
4. Specify your Social Security number in the "Social Security Number" field.

IMPORTANT: Any individual receiving health benefits through a City plan must have a valid Social Security number. If you, or your dependent, do NOT have a valid Social Security number at the time of enrollment, you will be granted a six-month grace period to obtain a Social Security number and provide it to DOE. After six months, benefits for any employee or dependent who has NOT provided a valid Social Security number will be terminated.

5. Specify your work AND home telephone numbers in the "Tel. No." field.
6. Specify your full home address, including house or building number and street name (but NOT including apartment number) in the "Home Address - Number and Street" field.
7. Specify your apartment number (if applicable) in the "Apt. No." field.

8. Specify your date of birth in the correct format (MM/DD/YY) in the "Date of Birth" field.
9. Select your gender (Male or Female) in the appropriate checkbox in the "Sex" field.
10. Specify your city in the "City" field.
11. Specify your 2-character state (for example, NY) in the "State" field.
12. Specify your 5-character zip code in the "ZIP Code" field.
13. Specify your country of residence (if not U.S) in the "Country" field.
14. Specify your marital status in the "Marital Status" field by selecting the appropriate checkbox. If you select any checkbox other than "Single," you must also write the effective date of the event in the correct format (MM/DD/YY) in the space provided.
15. Write **DOE** in the "Agency in which Employed or Retired From" field.
16. Indicate which union or welfare fund you are eligible for in the "Union or Welfare Fund" field. This field **MUST** be completed. All employees are eligible for a specific union or welfare fund based on their title. If you are unsure of which union or welfare fund you are entitled to, contact your ISC or HR representative.
17. If you are currently covered by a non-DOE City health plan (for example, because you have other City employment or your spouse/domestic partner has listed you as a dependent on their City benefits), write the name of that plan in the "Name of Current City Health Plan" field.
18. If you are currently covered by a non-City health plan (including Medicare):
 1. Check **YES** in the "Are you the contract holder on a non-City group health plan" field.
 2. Specify the name of the non-City health plan.

3. Specify the policy or ID number of the plan (if non-Medicare) OR the Medicare claim number in the "Policy, ID or Medicare Claim No." field.
4. Write a checkmark in the appropriate Medicare Part A and Medicare Part B boxes AND provide the effective dates of Part A and/or Part B coverage in the correct format (MM/DD/YY). You do not need to provide your Medicare benefit card to submit the application if you are an ACTIVE employee (retirees must submit this supporting documentation).

19. If you are electing retiree benefits:

1. Specify the name of your retirement system (TRS, BERS, etc.) in the "Retirement System (if Applicable)" field.
2. Specify the number of years of credited service you have in the "Yrs. Cred. Svc." field.
3. Specify the effective date of your retirement in the correct format (MMDDYY) in the "Retirement Date" field.
4. Specify your pension number in the "Pension Number (Retirees Only)" field.

Section E: Spouse/Domestic Partner Information

This section **MUST** be completed if you selected Married or Domestic Partnership in the "Marital Status" field in Section D, even if you are not choosing to cover your spouse or domestic partner under your DOE health benefits. This is to ensure that DOE records are up-to-date.

1. Provide the appropriate supporting documentation for the spouse or domestic partner.
 1. If you are specifying a spouse, provide a PHOTOCOPY of the marriage certificate from the appropriate City or County Clerk's office. Other marriage-related documents, such as marriage licenses or certificates issued by your place of worship, are not valid forms of supporting documentation.
 2. If you are specifying a domestic partner, provide a PHOTOCOPY of the City domestic partner registration.
2. Specify your spouse/domestic partner's LEGAL last name in the "Last Name" field.

3. Specify your spouse/domestic partner's LEGAL first name in the "First Name" field.
4. Specify your spouse/domestic partner's middle initial (if applicable) in the "M.I." field.
5. Specify your spouse/domestic partner's Social Security number in the "Social Security Number" field.

IMPORTANT: Any individual receiving health benefits through a City plan must have a valid Social Security number. If you, or your dependent, does NOT have a valid Social Security number at the time of enrollment, you will be granted a six-month grace period to obtain a Social Security number and provide it to DOE. After six months, benefits for any employee or dependent who has NOT provided a valid Social Security number will be terminated.

6. Specify your spouse/domestic partner's date of birth in the correct format (MM/DD/YY) in the "Date of Birth" field.
7. Specify your spouse/domestic partner's employment status.
 1. If you checked "Employed" or "Retired," specify whether they are/were employed by a NYC Agency or a non-City employer ("Other").
 2. If you specified that your spouse/domestic partner is EMPLOYED, specify the name of their City agency or non-City employer in the "Name of Spouse/Partner's Employer" field.
8. Specify whether the spouse/domestic partner will be covered under your DOE health plan.

IMPORTANT: If you specified that your spouse/domestic partner is currently employed by a City agency and is actively enrolled in a City health plan through that agency, the Yes box CANNOT be checked. This is because City employees cannot be covered under more than one City health plan at a time.

9. Specify whether your spouse/domestic partner is covered under a NON-CITY health plan (for example, through a private employer or under Medicare). If you specified that your spouse/domestic partner IS covered under a non-City health plan:
 1. Write the full name of that plan in the space provided.
 2. Specify the Policy or ID of the plan (non-Medicare) or the Medicare Claim Number (Medicare) in the "Policy, ID or Medicare Claim No." field.

3. Specify whether the non-City health plan covers only the spouse/domestic partner (individual) or if it is a family plan.
 4. Specify the effective date of coverage under the non-City health plan.
10. If you specified that your spouse/domestic partner IS covered under a health plan (City or non-City), specify whether you will be covered under the spouse/domestic partner's plan. If **YES**:
1. Specify the effective date of their coverage under the spouse/domestic partner's plan in MM/DD/YY format.
 2. If the plan they are covered under is a Medicare plan, specify whether their coverage is Medicare Part A and/or Part B, as well as the effective date of coverage in MM/DD/YY format.

Section F: Family Information

This section is ALWAYS required. Each line on the table should be used for a specific individual, as described below.

1. Complete the FIRST line of the table with your own personal information.
 1. Provide your LEGAL first name and last name in the "Name" column.
 2. Provide your date of birth in the correct format (MM/DD/YY) in the "Birth Date" column.
 3. Provide your Social Security number in the "Social Security Number" column.
 4. Specify your gender (**M** = Male/**F** = Female) in the "Sex" column.

NOTE: The "Full-Time Student," "Permanently Disabled," and "Drop Coverage" fields are not used for the employee line of the table.
 5. If you have chosen an HMO plan, indicate your choice of Primary Care Physician in the "Name" and "Number" fields. If you have chosen a HIP plan, indicate your choice of Medical Group in the "Name" and "Number" fields.
2. If you are adding or dropping your spouse/domestic partner, complete the SECOND line of the table.

1. Provide the spouse/domestic partner's LEGAL first name and last name (if different from your last name) in the "Name" column.
 2. Provide the spouse/domestic partner's date of birth in the correct format (MM/DD/YY) in the "Birth Date" column.
 3. Provide the spouse/domestic partner's Social Security number in the "Social Security Number" column.
 4. Specify the spouse/domestic partner's gender (**M** = Male/**F** = Female) in the "Sex" column.
 5. If you are DROPPING the spouse/domestic partner from your existing coverage:
 1. Check the "Drop Coverage" box.
 2. Provide a PHOTOCOPY of one of the following:
 - For a divorce: divorce decree (both sides of the document are required)
 - For a termination of domestic partnership: termination of domestic partnership certificate
 - For death of the spouse/domestic partner: death certificate
 - For an annulment: Dissolution of marriage certificate
 - For a court-ordered dependent or other court-ordered scenario: a copy of the court decree
 - For a dependent who has obtained other coverage: proof of other coverage, such as a copy of their insurance card or a benefits verification letter from the carrier or covered employee's employer.
 6. If you have chosen an HMO plan, indicate your choice of Primary Care Physician in the "Name" and "Number" fields. If you have chosen a HIP plan, indicate your choice of Medical Group in the "Name" and "Number" fields.
3. If you are adding or dropping a dependent child or children, complete the THIRD and/or FOURTH lines of the table.

NOTE: If you have more than two dependent children, you need to complete the corresponding lines on a second form. You DO NOT need to complete all other fields on the second form.

1. Provide the child's LEGAL first name and last name (if different from the employee's last name) in the "Name" column.
2. Provide the child's date of birth in the correct format (MM/DD/YY) in the "Birth Date" column.
3. Provide the child's Social Security number in the "Social Security Number" column.

IMPORTANT: Any individual receiving health benefits through a City plan must have a valid Social Security number. If you, or your dependent, do NOT have a valid Social Security number at the time of enrollment, you will be granted a six-month grace period to obtain a Social Security number and provide it to DOE. After six months, benefits for any employee or dependent who has NOT provided a valid Social Security number will be terminated.

4. Provide the child's gender (**M** = male/**F** = female) in the "Sex" column.
5. If you have chosen an HMO plan, indicate your choice of Primary Care Physician in the "Name" and "Number" fields. If you have chosen a HIP plan, indicate your choice of Medical Group in the "Name" and "Number" fields.
6. Select from below.

- ADDING a child under the age of 19

1. Provide a PHOTOCOPY of the appropriate supporting documentation. The following are examples of the appropriate supporting documentation for dependent children under the age of 19.

2. Select from below.

- Employee is the custodial parent

1. Child's birth certificate, **OR**
2. Hospital discharge papers **AND** the baby's footprints, **OR**
3. Hospital discharge papers **AND** letter from the hospital (if footprints not provided), **OR**
4. Child's birth certificate **AND** adoption papers

- Employee the non-custodial parent

1. Copy of the child's birth certificate **AND** copy of the court order instructing employee to include child on coverage.

- Employee is the father of a child and is not listed on the birth certificate

1. If the mother of the child is the employee's dependent, copy of the child's birth certificate, **OR**
 2. If the mother of the child is NOT the employee's dependent, copy of the letter of filiation (paternity) from the court AND a photocopy of the child's birth certificate.
- ADDING a child who is a full-time student between the ages of 19 and 23
 1. Write a checkmark in the "Full-Time Student" box.
 2. Provide a PHOTOCOPY of the child's birth certificate AND a letter from the college or university registrar confirming their full-time enrollment in an accredited college or university.
 - ADDING a child who is over the age of 19 and unable to work due to permanent disability
 1. Write a checkmark in the "Permanently Disabled" box.
 2. Provide a photocopy of the child's birth certificate AND a letter from the child's physician detailing the child's disability.
 - DROPPING a child from existing coverage (during the transfer period):
 1. Write a checkmark in the "Drop Coverage" box.
 2. Provide a PHOTOCOPY of the appropriate supporting documentation, including:
 - Child's birth certificate indicating that they are over-age
 - Court decree
 - Proof of child's coverage under a different health plan
 - Married child's (under 19) marriage certificate

Section G: Health Plan Requested

This section is always required UNLESS you are waiving your DOE benefits entitlement ("Waive Benefits" or "Buy-Out Waiver Program" selection in Section A). If waiving benefits, this section must be left BLANK.

1. CLEARLY PRINT the full name of the plan you have selected (for example, HIP Prime HMO or HIP Prime POS). For a list of plans, refer to the Summary Program Description (SPD) on the OLR website, at nyc.gov/olr.
2. Select **YES** or **NO** in the "Optional Benefits" field to indicate whether you would like to elect the optional rider(s) associated with your chosen plan. This is a critical field that CANNOT be left blank. If left, blank, the application will be processed as electing NO optional rider. If no optional rider is selected, be aware that you will not be able to elect an optional rider until the next open enrollment/transfer period (unless you move into or out of a union title, or in rare cases, obtain approval for a medical or financial hardship).

Section H: Employee Signature

The employee must certify that they have confirmed that all information provided in their application is true and accurate. The application will NOT be processed without a signature and date.

IMPORTANT: If you have changed your name, make sure you sign the form using your NEW name.

1. Sign and date this section ONLY if you are NOT participating in the health benefits buy-out waiver program.

Section I: Buy-out Waiver Program Participation

The employee must certify that they have confirmed that all information provided in their application is true and accurate.

IMPORTANT: If you have changed your name, make sure you sign the form using your NEW name.

1. Sign and date this section ONLY if you ARE participating in the health benefits buy-out waiver program.

Section J: Health Plan Requested

This section should be completed by your payroll secretary or HR representative UNLESS you are a new teacher who is enrolling in benefits before the beginning of the school year, as directed in the Jumpstart letter.

Related Topics

- NYCAPS Health Benefits Enrollment Form Checklist - Employees

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