Long Beach Public Schools
235 Lido Boulevard, Lido Beach, NY 11561
P: (516) 897-2112 • F: (516) 771-3952
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Michele Natali, Ed.D.
Executive Director, Human Resources

November 6, 2016

Dear LBCSD Insured Employee,

Open Enrollment for health insurance coverage runs from November 10, 2016 through December 2, 2016, and is your **once-a-year** opportunity to evaluate and make necessary changes to your health insurance enrollment elections (if you are already eligible for health insurance). Please carefully review all of the health benefit options and costs before making enrollment decisions for yourself and your eligible family members. Possible changes include:

1. Changing between Empire and HIP.
2. Adding dependents under federal regulations.

Changes made during the Open Enrollment period will become effective January 1, 2017.
You may make additional changes during the year if you experience a Qualified Change In Status (Marriage, Birth, Death, etc.) and notify Susannah Familetti, Sr. Personnel Clerk, Benefits, (sfamiletti@lbeach.org) in the Office of Human Resources **within 30 days of the date of the event in writing**. Please note that documentation such as marriage, birth or death certificates will be required. If you are making changes to your policy now, please fill out the District Health Benefits Option Form and either the PA Health Insurance Transaction Form for Empire or the Subscriber/Member Enrollment form for HIP, as appropriate. ***If you are electing to waive, the Option Form should be filled out with the proper documentation attached.***

If you are satisfied with your current health coverage elections, you are **not required** to make any changes and your coverage will **automatically** be carried forward for the next plan year.

*** EVERY insured employee is required to fill out and sign the ACTIVE EMPLOYEE INFORMATION UPDATE form (whether or not they are making changes), and return it to Susannah Familetti in the Benefits Office no later than 12/2/16*.**

WHAT IS CHANGING IN 2017? Effective January 1, 2017, the following changes will occur:
Cost of Health Care Premium: Empire is **anticipating** a 7.6% premium increase effective January 1, 2017, and HIP is implementing a 7.3% increase in 2017:

PLAN	COVERAGE	TOTAL MONTHLY PREMIUM 2016	TOTAL MONTHLY PREMIUM 2017
EMPIRE	Individual	$849.01 / month	$913.53/month
	Family	$1926.21 / month	$2,072.60 /month
HIP	Individual	$894.44 / month	$959.61/month
	Family	$2191.35 / month	$2,351.05/month

Attached you will find the following forms which should be returned to the Benefits Office no later than 12/2/16:

1.	**Health Benefits Option Form**	To be completed if you are **changing** from the Waive Option to Coverage, or Coverage to Waive.
2.	**Empire Enrollment Form**	To be completed ONLY if you are Electing New Empire Coverage.
3.	**HIP Enrollment Form**	To be completed ONLY if you are Electing New HIP Coverage.
4.	**Active Employee Info Update Form**	To be completed in its entirety by EVERY INSURED EMPLOYEE even if you are not making changes to your insurance. This ensures updated and accurate information.

Should you have any questions or for more information, please contact Susannah Familetti in the Benefits Office at 516-897-2095 or sfamiletti@lbeach.org.

Sincerely,

Susannah Familetti
Sr. Personnel Clerk

LONG BEACH CITY SCHOOL DISTRICT OPEN ENROLLMENT
ACTIVE EMPLOYEE INFORMATION UPDATE

***** Please complete and return to the Office of Human Resources by December 2, 2016. *****

PLEASE PRINT:

Legal Name: _____

Permanent Address: _____

_____

Home Phone Number: _____ Marital Status: _____

Cell Phone Number: _____ Email Address: _____

IF ELIGIBLE FOR BENEFITS, TYPE OF COVERAGE ELECTED:

(*Please check one for each that applies*):

EMPIRE: Individual _____ DENTAL: Individual _____

Family _____ Individual + Spouse _____

Waive** _____ Family _____

****Pursuant to NYSHIP rules, please attach copy of current insurance card.****

HIP: Individual _____ LIFE INSURANCE: _____

Family _____ EXCESS MAJOR MEDICAL: _____

Please complete this section even if you currently waive health insurance

DEPENDENT NAME(S)	RELATION	DATE OF BIRTH	SOCIAL SECURITY #

PLEASE SIGN BELOW:

I affirm that the information above is correct.

_____ _____

Signature Date

Please fill out this form if you are switching from "Waive "to "Enroll" or vice versa**

Health Benefits Option Form

Employee Name_____Title_____

☐ **New Coverage**

☐ Family ☐ Individual

☐ **Waive Coverage**

☐ Family ☐ Individual ☐ Family taking Individual

☐ **Change of Coverage**

FROM ☐ Family ☐ Individual ☐ Waive

TO ☐ Family ☐ Individual ☐ Waive

Effective Date of Eligibility_____

_____ _____

Employee Signature Date

☐ If Waiving Coverage – Attach Copy of Insurance Card

State of New York
Department of Civil Service
Alfred E. Smith State Office Bldg.
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

PA HEALTH INSURANCE TRANSACTION FORM

PS-503.1 (2/07L)

INSTRUCTIONS: READ AND COMPLETE BOTH SIDES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.

EMPLOYEE INFORMATION *(All employees must complete)*

1 Last Name / First Name / MI		2 Social Security Number	3 Sex ☐ Male ☐ Female
4 Street Address	City	State	Zip
5 Date of Birth	6 Telephone Numbers Home ( )_____ Work ( )_____		7 Work location and address
8 Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Marital Status Date		

9 Covered under Medicare? Self ☐Yes ☐ No Spouse/Domestic Partner ☐Yes ☐ No Dependent ☐Yes ☐ No

10 ENTER REQUEST(S) BELOW

A. ☐ Request Enrollment- **Individual**	For Agency Use: *(Select Empire Plan Option)* 7 (core plus med & psych)_____ 8 (core only)_____
B. ☐ Request Enrollment- **Family** (Complete G)	List dependents in section G — For Agency Use: *(Select Empire Plan Option)* 7 (core plus med & psych)_____ 8 (core only)_____
C. ☐ Decline Coverage	For Agency Use only: Process waive benefits transaction
D. ☐ Voluntarily Cancel Coverage	
E. ☐ Name Change	Previous Name was:

F. ☐ Change Coverage — Date of Event _____

Change to FAMILY (Complete G)
- ☐ Marriage
- ☐ Domestic Partner
- ☐ First dependent child acquired
- ☐ Dependent returned to full-time student status
- ☐ Request coverage for dependents not previously covered
- ☐ Newborn
- ☐ Previous coverage terminated (Complete Section 11)
- ☐ Other _____

Change to INDIVIDUAL
- ☐ I voluntarily cancel coverage for my dependents
- ☐ I voluntarily cancel coverage for my domestic partner
- ☐ Only dependent died
- ☐ Only dependent married
- ☐ Only dependent graduated
- ☐ Only dependent left school
- ☐ Divorce
- ☐ Only dependent disqualified by age
- ☐ Termination of domestic partnership *(Attach Completed PS-427.4)*
- ☐ Other _____

G. DEPENDENT INFORMATION *(use additional sheets if necessary)*

Check One: A (Add), D (Delete), C (Change), Medicare (M)
Date of Event _____

Is enrollee or spouse reimbursed by another agency? ☐Yes ☐ No

↓	Last Name	First Name	MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security #
☐A ☐D ☐C ☐M								
☐A ☐D ☐C ☐M								
☐A ☐D ☐C ☐M								
☐A ☐D ☐C ☐M								
☐A ☐D ☐C ☐M								

10 Cont'd — **ENTER REQUEST(S) BELOW**

H. ☐ Change Retiree Payment status Change to: ☐ pension deduction (Rate ____/____) ☐ direct payment to agency (APAY)

I. ☐ Correct Social Security Number Incorrect SSN:

11 — **PREVIOUS COVERAGE INFORMATION**

If you were previously covered under NYSHIP or another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.

Previous ID Number:	Date Coverage Terminated:
Enrollee's Name Under Which Previously Covered — Last	First / Middle Initial

12 — **LEAVE WITHOUT PAY AND RETIREMENT STATUS**

LEAVE WITHOUT PAY

☐ I wish to continue coverage while I am on authorized leave.
I understand that I will be billed for this coverage.

☐ I do not wish to continue coverage while I am on authorized leave.
I wish to resume my coverage upon return to the payroll.

RETIREMENT/ VESTEE STATUS

☐ I understand the requirements for continuing medical insurance coverage as a **retiree** and wish to continue my coverage.

☐ I understand the requirements for continuing medical insurance coverage as a **vestee** and wish to continue my coverage.

13 — **REQUEST FOR EMPIRE PLAN CARD**

☐ DUPLICATE CARD
(Previously issued card remains valid.)
☐ REPLACEMENT CARD
(Previously issued card(s), lost or stolen, become invalid.)

FOR
☐ ENROLLEE
☐ ENROLLEE AND ALL DEPENDENTS
☐ INDIVIDUAL DEPENDENT
Name _____

Personal Privacy Protection Law Notification

This information you provide on this application is being requested pursuant to Section 163 of the New York State Civil Service Law for the purpose of enabling the NYS Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by your Personnel Office and by the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For further information relating *only* to the Personal Protection Law, call (518) 457-9375. For information related to the Health Insurance Program, **contact your Agency Health Benefits Administrator.** If, after calling your Agency Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

AUTHORIZATION

I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving agency service (vest, retirement, etc.). **I certify that the information I have supplied is true and correct.** I understand that my failure to provide required proof(s) within 30 days may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a misstatement of fact or conceals any pertinent information, commits a crime which is subject to a $5,000 penalty *and* the stated value of the claim for *each* violation. I hereby ***authorize deduction from my salary or retirement allowance*** of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

Employee's Signature (Required) _____ **Signature Date (Required)** _____

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	First Eligibility Date	Agency Code	Date Eligibility Lost	Retirement System

Retirement Tier	Registration #	Pension Deductions		Date Entered on NYBEAS	Effective Date
		Yes_____	No_____		

HBA Signature: **Date:**

EmblemHealth

TRANSACTION FORM FOR GROUP ACCOUNTS

I. SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	Sex	Social Security Number

Street Address	Apt.	City	State	ZIP Code

Were you ever a member of EmblemHealth? ☐ NO ☐ YES
If YES, member ID _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner

Birth Date: Mo. Day Yr.

Home Tel. #: _____
Work Tel. #: _____
Cell Tel. #: _____

Email Address: _____

☐ **"GO PAPERLESS" and save trees (see back of form)***

Applicant's hours worked per week:
☐ at least 30 hours ☐ less than 30 hours ☐ COBRA

Type of Coverage: ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child

Note: If electing Young Adult Coverage, please submit a completed Young Adult Election Form.

Primary Care Physician Name: (Not required for EPO/PPO members) _____ ID Number: _____

OB/GYN Selection Name: (Optional) _____ ID Number: _____

Are you covered by any other health insurance or Medicare?
☐ NO ☐ YES If YES, indicate:
Insurance Co. Name: _____
Insurance Co. Telephone #: _____ Type of Coverage: _____
Policy #: _____ Effective Date: _____

Check One:
☐ New Enrollment
☐ Reinstatement
☐ Termination
☐ Change to Ind.

Status:
☐ Add Dependent
☐ Remove Dep.
☐ Address Change
☐ Name Change

Transfer:
☐ To Another Carrier
☐ EmblemHealth Group Change:
From: _____
To: _____

II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY

Note: A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

Last Name (if different)	First Name	Social Security Number	Sex	Relationship	Birth Date Mo.	Day	Yr.	✓ if Disabled[1]	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
DEPENDENT				☐ Spouse ☐ DP ☐ Child				☐		
Current Health Insurance Information:	Carrier Name: _____			Coverage Begin Date: _____				Coverage End Date: _____		
DEPENDENT				☐ Child				☐		
Current Health Insurance Information:	Carrier Name: _____			Coverage Begin Date: _____				Coverage End Date: _____		
DEPENDENT				☐ Child				☐		
Current Health Insurance Information:	Carrier Name: _____			Coverage Begin Date: _____				Coverage End Date: _____		

[1]For dependent adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Dependent" box, and follow the instruction for required documentation.

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant must sign here: _____ **Date:** _____

III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group:	Group Number:	☐ EmblemHealth ☐ GHI ☐ GHI HMO ☐ HIP Plan Name: _____	If you selected a small group metal plan, please check which type: ☐ Gold ☐ Silver ☐ Bronze
Requested Effective Date: Medical: _____ Dental: _____	Hire Date:	Waiting Period:	Date Submitted: / Approved By: (Group Plan Administrator)

Instructions to Benefit Administrators or Group Representatives: For groups with 50 employees or fewer, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

IMPORTANT INFORMATION

1. The subscriber must complete sections I and II. The group plan administrator must complete section III and if for a small group (50 employees or fewer), provide all necessary documentation.
2. All transactions are subject to EmblemHealth's retroactive enrollment period – members must be enrolled within 30 days (for small groups) or 90 days (for large groups) from the Qualifying Event/next billing date.
3. As part of New York State's "age 29" law, eligible young adults through age 29 may obtain coverage through a parent's group policy.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.
5. Return the completed Transaction Form along with any required documentation to: Membership, PO Box 2820, New York, NY 10116-2820.

Get more information at **www.emblemhealth.com**.

SECTION A

(To be completed by Benefits Administrator)

ACTION Check (✓)One	Qualifying Event	Documentation Required
☐ Add Subscriber	New Hire or Change in Plan	For eligible employees who work at least 30 hours per week, provide a recent Copy of NYS45 showing this subscriber as an employee or provide copy of payroll documentation reflecting the date, employee's name and Social Security #, or the employee's current-year W4 form.
☐ Add Spouse	Marriage	**If last name is different** ☐ Marriage Certificate ☐ 1040 Form
☐ Add Dependent	Birth or Adoption	**If last name is different** ☐ Birth Certificate ☐ Formal Adoption Papers ☐ Court Approved Guardianship Papers
☐ Add Young Adult	Young Adult Coverage	Young Adult Election Form
☐ Add Dependent	Dependent Adult Child Incapable of Self-Sustaining Employment	Disability Status Request Form
☐ Add Spouse ☐ Add Dependent	Loss of Coverage	Certificate of Creditable Coverage
☐ Add Domestic Partner	Domestic Partnership	Declaration of Cohabitation & Financial Interdependence form

Note: No exceptions to our retroactive enrollment period will be allowed. Small group members must be enrolled within 30 days from the Qualifying Event/next billing date (or within 90 days for large group members).

*By electing "Go Paperless," you will receive claim statements and some other EmblemHealth letters by email instead of paper mail. You will be able to view your Explanation of Benefits (EOBs) under the Claims section of the EmblemHealth website. Your enrollment in the "Go Paperless" option will continue as long as your account remains active, or until you choose to discontinue this option.