



Health Benefits Program

40 Rector Street - 3rd Floor, New York, NY 10006
(212) 513-0470 • TTY/TDD: (212) 306-7753
www.nyc.gov/olr

Health Benefits Report/Inquiry

Date: ____/____/____

Employee Retiree Second Request

Send To:	<input type="checkbox"/> AETNA HMO	<input type="checkbox"/> AETNA QPOS	<input type="checkbox"/> CIGNA HEALTHCARE	<input type="checkbox"/> DC37 MED-TEAM	<input type="checkbox"/> EMPIRE EPO
	<input type="checkbox"/> Empire HMO NY	<input type="checkbox"/> GHI/EBCBS	<input type="checkbox"/> GHI-HMO	<input type="checkbox"/> HEALTHNET	<input type="checkbox"/> HIP PRIME HMO
	<input type="checkbox"/> HIP Prime POS	<input type="checkbox"/> METROPLUS	<input type="checkbox"/> VYTRA HEALTH PLANS	<input type="checkbox"/> OTHER: _____	

REASON(S) FOR SUBMISSION (check one or more boxes)

Coverage Dates	STATUS CHANGE(S)	Date of Event (Effective Date)	STATUS CHANGE(S)	Date of Event (Effective Date)	OTHER
Start / / End / /		/ /		/ /	
<input type="checkbox"/> S.L.O.A.C Reason _____	<input type="checkbox"/> Reinstatement	/ /	<input type="checkbox"/> Change of Title	/ /	<input type="checkbox"/> Request ID Cards <input type="checkbox"/> Request for Refund
<input type="checkbox"/> FMLA LEAVE COVERAGE	<input type="checkbox"/> Termination	/ /	<input type="checkbox"/> Change of Welfare Fund	/ /	<input type="checkbox"/> Correction of Status <input type="checkbox"/> Deduction
	<input type="checkbox"/> Suspension	/ /	<input type="checkbox"/> Change of Address	/ /	<input type="checkbox"/> Claims Inquiry Claim # _____
					<input type="checkbox"/> Other _____

EMPLOYEE INFORMATION

Last Name			First Name		M.I.	Social Security Number		Agency in Which Employed		
Home Address				Apt.	Agency Code	Pay Period		Title Code No.	Job Sequence No.	
						<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Weekly				
City			State	Zip	Union or Welfare fund				Present Health Code	

EXPLANATION INQUIRY

RESPONSE FROM HEALTH PLAN

By	Department	Telephone Number	Date
		() -	/ /

PLEASE RETURN ORIGINAL TO AGENCY BENEFITS REPRESENTATIVE INDICATED BELOW

Agency Representative Must Complete this Section:			For Employee Benefits Program Use Only:	
Name		Title		
Agency		Telephone Number		
		() -		
Address				