TOWN OF WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

POSITION STATUS CHANGE CHECKLIST: PART-TIME ->FULL-TIME EMPLOYEE

Congratulations on your change in status with the Town of West Seneca! Your appointment is pending Town Board approval and meeting required contingencies with the Town of West Seneca.

As part of your transition from part-time to full-time status, we will need you to complete ALL REQUIRED DOCUMENTS in the change status packet.

Below is a list of the documents included in the change status packet**. ALL ARE REQUIRED** unless otherwise noted as optional. Please review your packet before submitting to Human Resources. Use the Document List below to check for completed form. Also, return the paperwork in the order of the Document List below.

DOCUMENT NAME	**CHECK WHEN COMPLETED**
ECO CHANGE FORM	☐
ERS APPLICATION	☐
HIGHMARK OF WNY ENROLLMENT FORM (HEALTH)**	☐
CSEAEBF ENROLLMENT FORM (DENTAL & VISION)	☐
NYSDCP ENROLLMENT FORM (OPTIONAL)	_____ Provided by HR upon Request

** If you will not be enrolling in health care coverage, you will need to complete the Waiver of Benefits on the Highmark of WNY Enrollment Form.

For your records:
BENEFIT EXPLANATION – WC & BC
POS201 PLAN INFORMATION

Upon completion of all required documents, your change status packet will be submitted to the Finance Department for set up in the payroll system. Please be aware that incomplete paperwork may delay your effective date.

If you have any questions, please feel free to reach out to me via email at lscibetta@ebchcm.com or phone at (716) 482-7582. I look forward to working together to support the Town of West Seneca.

Lisa Scibetta
HR Advisor to the Town of West Seneca

Employee Change Form Information

For Supplementary Payroll Certification Report of Personnel Change to Erie County

Effective Date:

Employee Data			
Social Security Number:		Retirement Number:	
Name (Last, First):		Veteran Exemption (Y/N):	
Street Address:		Dates of Service:	From: To:
City/Town:		Volunteer Firemen: (Y/N)	
Zip Code:		Dates of Service:	From: To:

Title – Classification – Salary Information			
Are you currently employed by the Town of West Seneca? (Y/N)			
If "yes", complete below. If "no", leave blank:		Must be completed:	
Current Title:		New Title:	
Current Salary:		New Salary:	
Type (Check One):	Meeting	Type (Check One):	Meeting
	Daily		Daily
	Hourly		Hourly
	Weekly		Weekly
	BiWeekly		BiWeekly
	Quarterly		Quarterly
	Annually		Annually
Classification: (Check One)	Competitive	Classification: (Check One)	Competitive
	Non-Competitive		Non-Competitive
	Labor		Labor
	Exempt		Exempt
	Unclassified		Unclassified

Employee Type – For Temporary Appointment, WRITE IN END DATE			
Full Time Permanent		Part Time Temporary Seasonal	
Full Time Provisional		Regular Part Time Permanent	
Full Time Temporary		Regular Part Time Temporary	
Part Time Regular Permanent		Full Time Contingent Permanent	
Part Time Temporary		Part Time Provisional	
Part Time Permanent		Regular Part Time Provisional	

Office of the New York State Comptroller
NYSLRS
New York State and Local Retirement System
110 State Street, Albany, New York 12244-0001
Fax Number: (518) 486-4382
For questions concerning Member Enrollment call: (518) 474-3081

Received Date

Employees' Retirement System Membership Registration
RS 5420
(Rev. 11/22)

Plan	Tier	Rate	Date of Membership (mm/dd/yyyy)

Registration Number

NYSLRS ID

Social Security Number *

Part 1: Employee – Read information provided on page 2. Complete part 1 and sign at the bottom of the form.

Employee's Last Name:	First Name:	Middle Initial:

Employee's Address:	Apt	City	State	Zip Code

Former Name: (if applicable)	Date of Birth (mm/dd/yyyy)	Sex
		☐ Male ☐ Female ☐ X

Are you receiving or about to receive a pension from a New York State or New York City public retirement system? ☐ Yes ☐ No
If yes, please indicate name of system: _____
Are you inactive or withdrawn from a New York State or New York City public retirement system? ☐ Yes ☐ No
If yes, please indicate name of system: _____
(NYS Teachers', NYS Employees', NYS Police and Fire, NYC Police Pension Fund, NYC Fire Pension Fund, NYC Board of Education, NYC Teachers', NYC Employees')

Part 2: Employer – See page 2 for additional information and instructions regarding the completion of this form.

Employer's Name:	Employer's Telephone:

Employer's Address:	Employer's Fax Number:

Job Code [1]	Employee Classification		
	☐ 12 Month ☐ 10 Month ☐ 12 M Provisional ☐ On Call ☐ Seasonal ☐ Substitute ☐ Per Diem	☐ Regular [2] ☐ Temporary	☐ Full Time ☐ Part Time

Hire Date [3a]			Date of Full-Time Permanent Appointment [3b]			Location Code	Standard Workday [4]	For State Agency Use Only – Agency Code
Month	Day	Year	Month	Day	Year			

For a substitute, seasonal, on call or per diem employee, please check if he/she/they is working on the day the application is being submitted. ☐ **Yes**

Frequency of Payment

☐ Weekly ☐ Bi-Weekly ☐ Semi - Monthly ☐ Monthly ☐ Quarterly ☐ Semi- Annually ☐ Annually ☐ Other- Please Specify_____

Projected Annualized Wage [5]

Tier 6 requires employers to determine the Annualized Wage for individuals who work part-time, seasonal, or on an hourly, daily, or unit of work basis. We ask that you use this calculation for all other tiers as well. See page 2 for examples.

Important: If your employment is on a part-time, temporary or provisional basis, or less than 12 months a year, membership is optional. If your membership is optional, you must sign and date below to affirm Retirement System Membership.
I acknowledge that my membership in the New York state and Local Retirement System is governed by provisions of Article 15 of the Retirement and Social Security Law and that I am entitled to all the benefits thereof. I understand that, as required by law, a deduction will be made from my salary or compensation for retirement contributions.

Employee's Signature:_____**Date:** _____

Employee's Telephone Number:	Employee's Email Address:

For important information and instructions – See Back Page

Part 1 – Employee Instructions

Important: If your employment is on a part-time, temporary or provisional basis, or less than 12 months a year, membership is optional. If your membership is optional and you **do not wish** to join the Retirement System, do not complete this application.

Warning: If you are receiving or are about to receive a pension from another New York State or New York City public retirement system, contact us directly before enrolling in NYSLRS. Enrollment may result in suspension of your pension benefit. NYSLRS retirees should contact us directly before enrollment to discuss working after retirement and possible restoration of membership.

Membership Information:

- If you are currently an active or vested member of any other public retirement system in New York State, you should contact that system concerning the advantages of transferring your membership to this System. Failure to contact that system could cause loss of the privilege of transferring membership and may affect contribution cessation dates.
- **If you were previously a member of any public retirement system in New York State, and your membership was terminated or withdrawn, you may be eligible for a reinstatement of that membership. It is highly recommended that if you have a prior Tier 1 or 2 membership in any New York public retirement system that you complete the Tier Reinstatement application, RS5506 and include it with your membership registration application.**
- You may also be eligible to receive credit for public service earned with a participating employer before your current date of membership. This additional service may impact your future benefits.
- You are covered by the Death Benefit allowed by law for your tier and plan status. If you have not already done so, complete an RS5127 Designation of Beneficiary with Contingent Beneficiaries form to designate beneficiary(ies) to receive an Ordinary Death Benefit. If there is no RS5127 Designation of Beneficiary with Contingent Beneficiaries on file with this System, your Ordinary Death Benefit will become payable to your estate.

Part 2 – Employer Instructions - Field Explanation and information:

[1] Job Code– As the employer, you will need to reference our job code list to determine which job code is applicable to the employee's job title. If the title is accountant, auditor, physician, attorney, engineer or architect, please submit documentation as indicated at https://www.osc.state.ny.us/retire/employers/employer_reporting_basics/emp-membership-basics/independent_vs_employee.php

[2] Regular is the same as Permanent or Probationary. Temporary is anything other than regular.

[3a] Hire Date is the first time the employee was hired for the job criteria entered.

[3b] Full-Time permanent appointment box must only be completed if at anytime the employee is appointed to a (permanent or probationary) 12 month, full-time position earning no less than current state minimum wage

[4] Standard Workday – A standard workday (hrs/day) applies to all tiers. The minimum number of hours that can be established for a standard workday is six, while the maximum is eight. A standard workday is the denominator to be used for the days worked calculation; it is not necessarily the number of hours the person actually works. For example, if a bus driver works four hours a day, you must still establish a standard workday between six and eight hours as the denominator for their days worked calculation. When entering the information on the Employer Retirement Online, you will need to select "Daily" for Work Period and then enter the standard work day in the standard day field.

[5] Projected Annualized Wage – Examples of Tier 6 annual wage for individuals paid at an Hourly, Daily or Unit of Work basis of compensation:

Hourly Employees 12 month Employee: $_____ X _____ X 260 = $_____ Hourly Rate / Standard Workday / Days Worked / Annual Wage 10 month Employee: $_____X _____ X 180 = $_____ Hourly Rate / Standard Workday / Days Worked / Annual Wage	**Daily Employees** 12 month Employee: $_____ X 260 = $_____ Daily Rate / Days Worked / Annual Wage 10 month Employee: $_____X 180 = $_____ Daily Rate / Days Worked / Annual Wage
Unit of Work Employees $_____ X_____ = _____ Unit Rate / # of Events** / Annual Wage **Estimated or Actual	**Unit of Work Employee Example: Paid $50 per Meeting** $ 50 X 12 Meetings = $ 600 Unit Rate / # of Events*** / Annual Wage ***An estimate of the number of events is acceptable

Note: Any questions regarding annualized wage, please contact the Retirement System.

***Social Security Disclosure Requirement**

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Sections 11, and 34 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

Personal Privacy Protection Law

The Retirement System is required by law to maintain records to determine eligibility for and calculate benefits. Failure to provide information may interfere with the timely payment of benefits. The System may be required to provide certain information to participating employers. The official responsible for record maintenance is the Director of Member and Employer Services, NYS and Local Retirement System, Albany, NY 12244; call toll-free at 1-866-805-0990 or 518-474-7736 in the Albany Area.

TOWN OF WEST SENECA

FINANCE DEPARTMENT

TOWN SUPERVISOR
GARY A. DICKSON

TOWN COUNCIL
WILLIAM BAUER
JOSEPH J. CANTAFIO
WILLIAM P. HANLEY JR.
JEFF PIEKAREC

Congratulations on your appointment with the Town of West Seneca!

As a full-time employee of the Town of West Seneca, you are eligible to receive the following health, dental and vision benefits. If you wish to enroll in any of the following benefits, complete the attached associated applications and remit them to the Finance Department as soon as possible.

Health Insurance Benefits

The Town of West Seneca currently utilizes Highmark of Western New York through the Labor Management Health Fund (LMHF) for its health insurance benefits and Pharmacy Benefits Dimensions for prescription coverage. The following is the pricing for the health benefits you are eligible for. A summary of the associated plans and enrollment application is attached for your convenience.

Plan	**BCBS POS201**	
	Single	**Family**
Monthly Premium Cost	$ 880.91	$ 2,477.39
Biweekly Contribution (20%)	$ 81.31	$ 228.68

Dental/Vision Insurance Benefits

The Town of West Seneca currently utilizes CSEA Employee Benefit Fund for it's dental and vision insurance benefits. You are eligible for dental and vision benefits at no cost to you. A summary of the associated plans and enrollment application is attached for your convenience.

For questions regarding health, dental and vision benefits, please contact Alissa Straus, Director of Finance at 716-558-3208 or astraus@twsny.org.

30928

HIGHMARK WESTERN NEW YORK

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY IN BLUE OR BLACK INK. DO NOT USE PENCIL OR HIGHLIGHTER.

❑ **ENROLLING** (Complete sections I, II, IV, and V)

❑ **WAIVING** (Complete sections I and III)

I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer/Group Name	Group Number	Payroll Location

First Name	MI	Last Name	Social Security Number *(If no SS#, write N/A)*

Address

City	State	Zip	County	Home/Cell Phone

Marital Status *(Please check one)*:
❑ Single/Widowed
❑ Married
❑ Divorced

Full-Time Hire (or Rehire) Date *(Month/Day/Year)*

_____/_____/_____

Enrollment Status
❑ Active Employee
❑ Rehired Employee
❑ Retiree
❑ HIPAA Life Event

Life Event
❑ COBRA Continuant Start Date _____/_____/_____
❑ Divorce
❑ Death of Spouse
❑ Loss of Student Status
❑ Dependent reached max age
❑ Left employ/retirement
❑ Add Dependent

Gender	Date of Birth *(Month/Day/Year)*	Age	Product Selection(s)
❑ M ❑ F ❑ U	/ /		❑ Medical Product Name: _____ ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
		❑ Yes ❑ No

II DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet.)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You?
			❑ Spouse ❑ Domestic Partner †

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ M ❑ F ❑ U	/ /	

Product Selection(s):
❑ Medical ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient?
		❑ Yes ❑ No

† If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child
			❑ Step-child ❑ Adopted* ❑ Other*

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ Male ❑ Female	/ /	

Product Selection(s):	Dependent Status if Age 26 or Older
❑ Medical ❑ Vision ❑ Dental	❑ Disabled ❑ Act 4**

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient?
		❑ Yes ❑ No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

30928

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other*
Social Security Number *(If no SS#, write N/A)*		Gender ❑ M ❑ F ❑ U	Date of Birth *(Month/Day/Year)* / / Age
Product Selection(s): ❑ Medical ❑ Vision ❑ Dental			Dependent Status if Age 26 or Older ❑ Disabled ❑ Act 4**
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other*
Social Security Number *(If no SS#, write N/A)*		Gender ❑ M ❑ F ❑ U	Date of Birth *(Month/Day/Year)* / / Age
Product Selection(s): ❑ Medical ❑ Vision ❑ Dental			Dependent Status if Age 26 or Older ❑ Disabled ❑ Other
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

III WAIVER OF COVERAGE (Complete this section ONLY if you are declining coverage(s) offered to you AND/OR your family members.)

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**:
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

REASON FOR DECLINING MEDICAL COVERAGE:

- ❑ Insured under spouse
- ❑ Other

_____

VISION

I HEREBY DECLINE VISION COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer and that I have declined coverage formyself and/ormy dependents as noted above. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed fivethousand dollars and the stated value of the claim for each such violation.

_____ _____

Employee/Contract Holder Signature Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 30 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your employer or call the toll-free Highmark Member Service number: 1-800-241-5704 (TTY/TDD: Dial 711).

IV OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date	Name of Policyholder
		/ /	

Policyholder Date of Birth	Relationship to Policyholder	Policy Number	Policyholder Employment Status
/ /			❑ Active ❑ Retired Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

V IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

To the best of my knowledge and belief, the information provided on this application is true and correct.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of the Highmark Notice of Privacy Practices is available on the Highmark Web site, or from the Highmark Privacy Office.

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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Print Employee/Contract Holder Name

Print Employer/Group Name

Employee/Contract Holder Signature

Date

For New Group Business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and all supporting documentation) to the appropriate Highmark Small Group Sales Contact.

For Ongoing Enrollment: If adding new employees/contract holders/or dependents to an existing group, please fax/send Enrollment/Waiver Forms to one of the following addresses:

Fax (833) 619-5746

enrollmentandbillinghighmarkny@highmark.com

Membership Department
P.O. Box 4208
Buffalo, NY 14240-4208

Notice of Nondiscrimination

The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার িডে তালিকাভু ক্ত নম্বরর ৃরে তা পররে বায় ৃ ান করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

CSEA Employee Benefit Fund Enrollment Form

PO Box 516
Latham, NY 12110
800-323-2732
www.cseaebf.com

Employee Information (Please Print)

Social Security # _____ Date of Birth _____ /_____ /_____

Name (First, Middle Initial, Last) _____ Please (✓) one: ❑ M ❑ F

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Employee's Daytime Phone # _____ Email _____

Name of Employer _____

Spouse/Domestic Partner Information

Please (✓) one: ❑ Spouse ❑ Domestic Partner* Date of Marriage _____ /_____ /_____ Please (✓) one: ❑ M ❑ F

Name (First, Middle Initial, Last) _____

Date of Birth _____ /_____ /_____ Social Security # _____

Dependent Children Information (For relationship, please indicate: Son, Daughter, Step-child or other)

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

If you are enrolling for a CSEA EBF Dental Plan, please answer the following: Do you and/or your dependents have other dental coverage available? ❑ Yes ❑ No

If yes, please indicate: Name of other plan: _____ Effective Date: _____ /_____ /_____

*Important Information concerning dependent coverage

- *Not all employers allow domestic partner coverage.* For New York State Employees; before enrollment of a domestic partner can be completed, the CSEA EBF must receive eligibility confirmation from The NYS Department of Civil Service. For Local Government employees, the confirmation must come from your employer. For purposes of IRS reporting, it is necessary that you provide your domestic partner's social security number on this form.
- When enrolling dependent children, it may be necessary for the CSEA EBF to require and/or request additional information which may include full-time student verification for children ages 19 and over, verification of eligibility by "Proof of Dependency" form, copy of Birth Certificate and/or "Certification of Disability" form.
- In certain instances, a copy of a Marriage Certificate may be requested for proof of eligibility.
- An employee may not be covered both as an employee and as a dependent of an employee. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are EBF members, coverage may not be claimed under both plans.

For a detailed outline of eligibility rules, please refer to your Summary Plan Description or visit our website at www.cseaebf.com

I certify that the above information is correct:

Member's Signature _____ Date _____

Labor-Management Healthcare Coalition ™

Town of West Seneca

Summary of Benefits

Traditional Blue POS 201/201Plus

Deductibles/Maximums	POS 201	POS 201 Plus
In-network deductible	N/A	
In-network co-insurance	N/A	
Medical in-network out-of-pocket maximum	$5,125/$10,250	
Pharmacy in-network out-of-pocket maximum	$1,725/$3,450	
Out-of-network deductible	$250/$500	
Out-of-network coinsurance	20%	
Out-of-network out-of-pocket maximum	$2,000/$4,000	
Annual maximum	Unlimited	
Lifetime maximum	Unlimited	
Benefit administration	Calendar year	
Dependent age	26	
Student age	26	
Dependent/Student coverage ends	End of birth month	
Domestic partner	No Coverage for domestic partner	
Prescription Drug	POS 201	POS 201 Plus
Prescription copay	$1/$10/$25	
Mail order copay per 90-day supply	1copay	
Option 90 - 90 day supply at retail	2.5 copays	
Physician Services - Office	POS 201	POS 201 Plus
Primary care physician copay	$5	$0 or $5
Specialist copay	$10	$15 or $10
Pediatric visits for children up to age 19	Covered in full	
Well child visits and immunizations for children up to age 19	Covered in full	
Allergy immunotherapy	$10	$15 or $10
Chiropractic	$5	$5
Laboratory services	Covered in full	
Radiology (X-ray, MRI, CT and other high-tech imaging)	Covered in full	
Pre and post natal care	Covered in full after initial primary care physician copay	
Physician Services - Preventive	POS 201	POS 201 Plus
Abdominal aortic aneurysm screening	Covered in full	
Adult immunizations (flu vaccinations covered in full)	Covered in full	
Bone mineral density screening	Covered in full	
Routine colorectal cancer screening	Covered in full	
Routine mammogram	Covered in full	
Routine OB/GYN	Covered in full	
Routine pap smear	Covered in full	
Routine physical exam	Covered in full	
PSA test	Covered in full	
Routine eye exam	Covered in full	

Labor-Management Healthcare Coalition ™

Town of West Seneca

Summary of Benefits

Traditional Blue POS 201/201Plus

Hospital	POS 201	POS 201 Plus
Inpatient hospital stay	Covered in full	
Inpatient maternity stay	Covered in full	
Outpatient surgery	$10	$15 or $10
Emergency Hospital Care	POS 201	POS 201 Plus
Emergency room (copay waived if admitted to hospital)	$35	
Ambulance - ground	Covered in full	
Ambulance - air	Covered in full	
Urgent care centers	$5	$0 or $5
Mental Health and Substance Abuse	POS 201	POS 201 Plus
Inpatient mental health	Covered in full	
Outpatient mental health	Covered in full	
Inpatient alcohol & substance abuse detoxification	Covered in full	
Inpatient alcohol & substance abuse rehabilitation	Covered in full	
Outpatient alcohol & substance abuse	Covered in full	
Other Services	POS 201	POS 201 Plus
Cardiac rehabilitation (24 visits within 12 weeks of acute episode)	$10	$15 or $10
Chemotherapy	$10	$15 or $10
Dialysis	$10	$15 or $10
Durable medical equipment	20% copay	
Home care	$10	$15 or $10
Hospice	210 days, Covered in full	
Physical, speech and occupational therapy (30 visits)	$10	$15 or $10
Prosthetic and orthotic appliances	20% copay	
Radiation therapy	$10	$15 or $10
Skilled nursing facility	Unlimited days, Covered in full	
Lasik Eye Surgery (up to $400 each eye)	50% copay	50% copay
Wellness Benefit	POS 201	POS 201 Plus
Wellness Card	$250	

revised 1/1/2016 (0001, 0003, 0004, 0002, 0005, 0006)

***This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply.*