HEALTH BENEFITS REPORT/INQUIRY

Date:

☐ Employee
☐ Retiree
☐ Second Request

CITY OF NEW YORK HEALTH BENEFITS PROGRAM

SEND TO:

☐ AETNA HMO ☐ AETNA QPOS ☐ CIGNA HEALTHCARE ☐ DC 37 MED-TEAM ☐ EMPIRE EPO
☐ EMPIRE HMO NY ☐ GHI-CBP/EBCBS ☐ GHI-HMO ☐ HEALTHNET ☐ HIP PRIME HMO
☐ HIP PRIME POS ☐ METROPLUS ☐ VYTRA HEALTH PLANS ☐ OTHER _____

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

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

EMPLOYEE PAYROLL INFORMATION

Last Name	First Name	M.I.	Home Address-Number and Street	Apt. No.	City	State	Zip Code

Social Security Number	Agency in Which Employed	Agency Code	Pay Period	Title Code No.	Union or Welfare Fund	Job. Seq. No.	Present Health Code
			☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Semi-Monthly				

EXPLANATION INQUIRY

RESPONSE FROM HEALTH PLAN

By: _____ Dept.: _____ Telephone No.: _____ Date: _____

PLEASE RETURN ORIGINAL TO AGENCY BENEFITS REPRESENTATIVE INDICATED BELOW.

Agency Representative Must Complete this Section:

Name: _____ Title: _____

Agency: _____ Phone: _____

Address: _____

For Employee Benefits Program Use Only: