HEALTH BENEFITS REPORT/INQUIRY

Date:

☐ Employee
☐ Retiree
☐ Second Request

CITY OF NEW YORK HEALTH BENEFITS PROGRAM

SEND ☐ VYTRA HEALTHCARE ☐ EMPIRE BLUECHOICE ☐ GHI-TYPE C/EBCBS ☐ HIP/HMO ☐ METROPLUS HEALTH PLAN (HHC ONLY) ☐ AETNA U.S. HEALTHCARE HMO ☐ OTHER

TO: ☐ CIGNA HEALTHCARE ☐ GHI-CBP/EBCBS ☐ HIP CHOICE PLUS ☐ MED-TEAM ☐ AETNA U.S. HEALTHCARE Q.P.O.S. ☐ PHYSICIANS HEALTH SERVICES _____

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

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

AGENCY BENEFITS REPRESENTATIVE