HEALTH BENEFITS REPORT/INQUIRY

Date:

☐ Employee
☐ Retiree
☐ Second Request

CITY OF NEW YORK HEALTH BENEFITS PROGRAM

SEND TO: ☐ VYTRA HEALTHCARE ☐ EMPIRE BLUECHOICE ☐ GHI-TYPE C/EBCBS ☐ HIP/HMO ☐ METROPLUS HEALTH PLAN (HHC ONLY) ☐ AETNA U.S. HEALTHCARE HMO ☐ OTHER
☐ 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.	/ /	/ /	☐ Reinstatement	/ /	☐ Change of Title	/ /	☐ Request ID Cards	☐ Request for Refund
Reason _____			☐ Termination	/ /	☐ Change of Welfare Fund	/ /	☐ Correction of Status	☐ Deduction
☐ FMLA LEAVE COVERAGE	/ /	/ /	☐ 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 ☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Semi-Monthly	Title Code No.	Union or Welfare Fund	Job. Seq. No.	Present Health Code

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:

EB1054 (9/03) 50M

AGENCY BENEFITS REPRESENTATIVE