



Catastrophe Major Medical Plan Enrollment Form

Sponsored by NYSUT Member Benefits Catastrophe Major Medical (CMM) Insurance Trust
Group Policy CMMI-003

OPEN ENROLLMENT PERIOD: MAY 1, 2017 - JUNE 15, 2017

COVERAGE EFFECTIVE: JANUARY 1, 2018

APPLICATION TYPE: New Coverage (Please complete all sections) Add Dependent (s) To Current Coverage (Please complete Sections 2, 3 and 5)

INSTRUCTIONS

1. Complete, sign and date the enrollment form including dependent information, if applicable.
2. Mail the completed form by June 15, 2017 to:

NYSUT Member Benefits - CMM
 800 Troy-Schenectady Road
 Latham, NY 12110-2455
 Fax: 518-213-6413
3. Upon receipt and processing, you will receive a premium invoice 45 days prior to the January 1, 2018 coverage effective date. Coverage will not begin unless the premium is received by December 31, 2017.
Questions? Call Mercer Consumer at 888-386-9788.

Section 1: NEW COVERAGE ELIGIBILITY

1. Do you currently reside in New York State? Yes No
2. Are you currently employed in a position where you are represented for purposes of collective bargaining by a NYSUT Affiliate?
 Yes No
3. Are you covered by or insured under a Basic Plan (see Additional Information on the following page)?
 Yes No

If yes, please provide the Basic Plan information:

Insurance Company: _____ Policy # _____

(If there are multiple policies please use a separate sheet.)

Note: If you are a new enrollee and have answered “No” to #1, #2, or #3 above, you are not eligible to enroll.

Section 2: MEMBER INFORMATION

NYSUT ID#	Marital Status	
Last	First	MI
Address	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	Zip
Phone(s) _____(Primary) _____(Alternate)	E-mail	

Section 3: DEPENDENT INFORMATION

- Complete the following to enroll your eligible spouse/domestic partner and/or eligible children. Proof of dependent status must be submitted with this enrollment form (see Additional Information on the following page).
- All eligible dependents are required to be covered by or insured under a Basic Plan (see Additional Information on the following page). Please provide Basic Plan information where indicated.
- Children must be under the age of 30 on December 31, 2017 to be enrolled.

(Use a separate sheet of paper if more space is needed.)

Name (Last, First, Middle Initial)		
Spouse/Domestic Partner:	Gender	Date of Birth
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Basic Plan Information Insurance Company: _____ Policy # _____		
Child:		
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Basic Plan Information Insurance Company: _____ Policy # _____		
Child:		
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Basic Plan Information Insurance Company: _____ Policy # _____		

Section 4: PAYMENT INFORMATION

In November 2017 you will receive an invoice with payment options for the period 1/1/2018 - 6/30/2018.

NOTE: Enrollment will not be complete and coverage will not begin unless payment is received by 12/31/2017.

Section 5: READ, SIGN AND DATE

I understand that coverage shall become effective **January 1, 2018**.

NEW ENROLLEES:

I understand that this plan requires that:

1. I reside in New York State at the time of enrollment;
2. I am employed in a position where I am represented for purposes of collective bargaining by a NYSUT Affiliate at the time of enrollment; and
3. All eligible participants must be covered by or insured under a Basic Plan (see Additional Information on the following page).

PARTICIPANTS ADDING DEPENDENTS:

I understand that this plan requires that all eligible dependents must be covered by or insured under a Basic Plan (see Additional Information on the following page).

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurer or self-insurer in connection with an application for insurance or statement of claim that contains any false or incomplete information commits a fraudulent act that may be a crime and may subject such person to incarceration, fines and denial of benefits. Coverage may be retroactively terminated if such fraud is discovered.

Member's Signature _____ Date _____

Mail this form to: NYSUT Member Benefits - CMM, 800 Troy-Schenectady Road, Latham, NY 12110-2455
Agency fee payers to NYSUT are eligible to participate.

IMPORTANT: SUBMISSION MUST BE POSTMARKED BY JUNE 15, 2017

ADDITIONAL INFORMATION

Basic Plan means any and all of the following Plans in which an eligible participant is enrolled:

- New York State Health Insurance Program's Empire Plan (NYSHIP);
- New York City Health Insurance Program (NYC);
- Plan offered by Member's Employer (e.g., Article 47/Consortium plan, Article 43 plan or employer-sponsored plan) that provides Minimum Essential Coverage and Minimum Value within the meaning of the Affordable Care Act;
- Other group health plan, including the group health plan of a spouse or dependent, that provides Minimum Essential Coverage and Minimum Value within the meaning of the Affordable Care Act; or
- For Medicare-eligible participants, Parts A and B or Part C (Medicare Advantage Plan).

You must have Basic prescription drug coverage in order for prescription drug benefits to be payable. If a participant is a Medicare-primary beneficiary, he or she must be enrolled in a Part D Plan or have Creditable prescription drug coverage (as defined by Medicare) through another Basic Plan. No benefits for prescription drugs will be payable under this Plan for individuals who are not enrolled in a prescription drug program.

A Basic Plan does not include an individual Plan either purchased on or off any state/federal Marketplace/Exchange.

Tip: Your Basic Plan information can be found on your Medical Insurance ID Card.

Proof of dependent status includes a copy of the following:

- **Spouse/Marriage:** Marriage certificate.
- **Child/Birth:** Birth certificate showing biological child of the covered NYSUT Member.
- **Stepchild:** Birth certificate, divorce decree and marriage certificate.
- **Adoption or placement for adoption:** Court order signed by the judge showing that the covered NYSUT Member has adopted or intends to adopt the child and a copy of the birth certificate.
- **Foster Child:** Court order documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgment, decree or court order from a court of competent jurisdiction, plus a copy of the child's birth certificate and proof of any state-provided health coverage.
- **Disabled Dependent Child:** Current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically disabled and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on you and/or your spouse for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of dependent child including proof that the child is claimed as a dependent for federal income tax purposes.
- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document signed by a judge or a National Medical Support Notice.
- **Domestic Partner:** Signed affidavit by the covered NYSUT Member and domestic partner and proof that they meet the requirements of the Plan's domestic partner eligibility. The Domestic Partner Affidavit is available free of charge at memberbenefits.nysut.org and clicking "Open Enrollment Materials - Catastrophe Major Medical Plan" or by contacting Mercer Consumer, the Administrator, at 888-386-9788.