



The Medical Spending Conversion Program is a division of the
Office of Labor Relations' Pre-Tax Benefits Program
PLAN YEAR 2005 ENROLLMENT/CHANGE FORM
MEDICAL SPENDING CONVERSION (MSC)
PREMIUM CONVERSION PROGRAM
40 Rector Street, 3rd Floor, New York, NY 10006-1705 (212) 306-7760 / TTY: (212) 306-7629
nyc.gov/html/olr

Do not write in this box
Agency Payroll Code: _____
Employee Number: _____

INSTRUCTIONS: Please review the MSC sections in the Flexible Spending Accounts Program brochure and see instructions on reverse side of this form before completing.

ENROLLMENT Open Enrollment (September 20 - November 30, 2004; effective January 1, 2005) Complete Sections I, II, and IV.
(Check one): Mid-Year Enrollment (January 1 - November 15, 2005; effective Qualifying Event date) Complete Sections I, II, III, and IV.

I. EMPLOYEE (PARTICIPANT) INFORMATION (Please print.)

Last Name:		First Name:		M.I.:	Social Security Number:	
Home Address - Number and Street:			Apt. No.:	City:		State:
Home Phone Number (Area Code): ()			Work Phone Number (Area Code): ()		E-Mail Address:	
Agency Name (Not Division): (CUNY and HHC employees, please specify name of college or hospital.)						

II. MSC PREMIUM CONVERSION PROGRAM SECTION: Complete this section if you are changing your health premium tax status. If you are completing this form mid-year, you must also complete Section III below.

PREMIUM CONVERSION WAIVER AGREEMENT (Check A or B) Note: Changing your health premium status **will not** change your health plan.

- A) I have read the MSC Premium Conversion Program materials and I am choosing to decline the conversion of my health plan deductions to pre-tax status.
 I **decline** to participate in the MSC Premium Conversion Program (pre-tax to post-tax status).
- B) I have read the MSC Premium Conversion Program materials and I am choosing to rescind the conversion of my health plan deductions from post-tax status.
 I **rescind** my declination in the MSC Premium Conversion Program (post-tax to pre-tax status).

III. MID-YEAR QUALIFYING EVENT: Newly eligible employees or current employees changing their status during mid-year must complete this section.

This is to certify that I incurred the Qualifying Event(s) indicated in Section III and, therefore, wish to modify my benefits as indicated. I understand that the change(s) requested must be consistent with the Qualifying Event and that I must submit this form with legal/supporting documentation of all changes to my agency benefits office and they must be received by the MSC Administrative Office within 31 days of the Qualifying Event to take effect.

QUALIFYING EVENT	DOCUMENTATION (MUST BE ATTACHED)
<input type="checkbox"/> Beginning or termination of employment (<input type="checkbox"/> self <input type="checkbox"/> spouse)	Letter from employer/Agency Benefits Manager
<input type="checkbox"/> Unpaid leave of absence (<input type="checkbox"/> self <input type="checkbox"/> spouse)	Letter from employer/Agency Benefits Manager
<input type="checkbox"/> Return from unpaid leave of absence (<input type="checkbox"/> self <input type="checkbox"/> spouse)	Letter from employer/Agency Benefits Manager
<input type="checkbox"/> Marriage, birth, or adoption of a child	Marriage certificate, birth certificate, or adoption agreement
<input type="checkbox"/> Divorce, annulment, legal separation, or death	Divorce or annulment decree, separation agreement, or death certificate
<input type="checkbox"/> Change from p/t to f/t employment or vice versa (<input type="checkbox"/> self <input type="checkbox"/> spouse)	Letter from employer/Agency Benefits Manager
<input type="checkbox"/> Significant change in health coverage due to title change (<input type="checkbox"/> self <input type="checkbox"/> spouse)	Letter from employer/Agency Benefits Manager
<input type="checkbox"/> Increase in health plan deductions by more than 20%	Letter from employer/Agency Benefits Manager
<input type="checkbox"/> Moving out of an HMO service area	Letter from health plan

IV. EMPLOYEE SIGNATURE

I have read the MSC Program materials and instructions and I attest that I meet the qualifications to decline or rescind my declination from the MSC Program.

Signature: _____ Date: ____ / ____ / ____

V. FOR COMPLETION BY BENEFITS/PAYROLL PERSONNEL ONLY: Please review the above information before completing the information below.

Note to Benefits/Payroll Officer: Send this MSC Form along with any legal/supporting documentation, to the address above. You should retain a copy of this form for your records.

- 1) **For the Premium Conversion Program,** I have changed the employee's health premium status.
Non-PMS Payroll effective date: ____ / ____ / 2005
- 2) **For mid-year changes,** I certify that a **Qualifying Event** listed in Section III has occurred **within 31 days** of this request **and** this form along with legal/supporting documentation have been submitted.

Benefits Officer's Signature: _____ Date: _____ Agency Code: _____

Phone Number: () _____

MSC ADMIN. OFFICE USE ONLY	Pre-tax effective date: _____	Post-tax effective date: _____
	Processing date: _____	Processor: _____

**MEDICAL SPENDING CONVERSION (MSC)
PLAN YEAR 2005**

INSTRUCTIONS:

PREMIUM CONVERSION PROGRAM

The Medical Spending Premium Conversion Program allows you to pay for health plan deductions on a pre-tax basis. This program is automatic, however, it is not mandatory. Refer to the MSC sections in the Flexible Spending Accounts Program brochure for detailed information.

If you pay a premium for your New York City health benefits coverage, you may decline to pay for those premiums on a pre-tax basis by completing Section II.

Your waiver of this benefit will remain in effect indefinitely unless you experience an approved Qualifying Event mid-year or change to pre-tax status during the Open Enrollment Period (September 20 to November 30, 2004). In mid-year, you must notify the MSC Program Administrative Office within thirty-one (31) days of the Qualifying Event in order for the change to be effective.

If you wish to change your post-tax status, please complete Section II, by checking the box, to rescind your declination. If you are rescinding your declination mid-year, you must also complete Section III.

Please Note:

This form is not valid if you have not completed Section I, II, III (for mid-year) and IV.

This form is not valid if Section V has not been completed by your Benefits/Payroll Officer.