

# 2024 Dental Open Enrollment/Change Form

For NYCT SSSA/TSO Operating & Queens Division/TSO MSII/TSO SSII/MTA Bus TSO Local 106/Special Inspector (UFLEO) Retirees with NYSHIP Health Plan



**HR-BEN-836R**

## Section 1 - Information and Instructions

Complete this form to enroll in **or** change your dental insurance coverage.

This form is **only** for NYCT SSSA/TSO Operating & Queens Division/TSO MSII/TSO SSII/MTA Bus TSO Local 106/Special Inspector (UFLEO) retirees and/or their dependent(s) who are enrolled in the NYSHIP Health Plan.

Do **NOT** complete this form if you are enrolled in one of the Aetna plans for your medical coverage. Please do **NOT** submit this form if you are making your dental plan changes online.

It is important to complete **ALL** applicable sections of this form. You **MUST** submit a new request if there are any changes in the below information.

Completed and signed forms may be submitted via fax to 212-852-8700 **OR** via email to [BSC-Benefits@mtabsc.org](mailto:BSC-Benefits@mtabsc.org).

If you have questions, contact the Business Service Center (BSC) at 646-376-0123, 8:30AM - 5:00PM, Monday to Friday **OR** [BSCService@mtabsc.org](mailto:BSCService@mtabsc.org).

## Section 2 - Retiree Information

Print Name	Last	First	M.I.	BSC ID#
Phone (Cell)	Phone (Home)			E-Mail

If your address is incorrect, please log onto [www.mymta.info](http://www.mymta.info) to update your address or to obtain the *HR-HRIS-012 Employee Data Change Form*. An incorrect address will delay the receipt of important plan enrollment confirmation info.

## Section 3 - Dental Coverage Election (Effective January 1, 2024)

**DENTAL:** Individual  Family

Check only **ONE** of the below dental plans:

**CIGNA Dental Care (DHMO)**

**CIGNA DPPO Dental**

## Section 4 - Dependent Information

### ADD, REMOVE, OR CHANGE DEPENDENT(S):

Please fill in all information for dependents you wish to add (enroll), remove (delete), or change, and submit the required documentation (see Section 6 of this form). Use a separate sheet if more space is needed. Failure to submit required documentation will result in your request **NOT** being processed.

If you are found to be covering an ineligible dependent, coverage will be terminated retroactive to the date of the ineligibility and New York City Transit (NYCT) will pursue financial restitution for claims and/or premiums for the ineligible dependent(s).

### DOMESTIC PARTNER:

Please contact the MTA Business Service Center for the Domestic Partnership Package if you wish to enroll a domestic partner. Your domestic partner will **not** be enrolled in dental coverage unless a Domestic Partner Package is submitted and approved by the Benefits Department. If you are removing a Domestic Partner, please complete and submit this dental open enrollment/change form along with the Termination of Domestic Partnership Form.

Indicate (A) Add, (R) Remove, or (C) Change			Relationship (Check only <b>ONE</b> )			Gender			Date of Birth		
A	R	C	Spouse	Domestic Partner*	Child	F	M	X	MM	DD	YYYY

## Section 5 - Signature and Authorization

I do hereby certify that to the best of my knowledge, the above information is true and correct. My signature and date on this form certifies and warrants all dependent eligibility information is true, correct, and current. I also certify that dependent children from age 19 to 26 I have enrolled are eligible for MTA-sponsored coverage.

Retiree Signature:

Date:

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## HR-BEN-836R

### Section 6 - Required Supporting Documentation

#### 1. For a Spouse:

A copy of your Marriage Certificate, Birth Certificate, and Social Security Card are **required**. In place of the required Birth Certificate, any one (1) of the following official government documents can be alternatively submitted:

- Letter from Social Security Administration containing your spouse's date of birth
- Valid US Passport **or** Resident Alien Card
- Valid Driver's License (New York)
- Public Assistance ID Card
- Government Employment ID

**AND**

**If your date of marriage is more than one (1) year old, proof of joint ownership is also required.** If your marriage date is less than 1 year old, such proof is not required. **If removing a spouse due to divorce, submit the first and last page of the divorce decree showing the court filing date.**

**Both the enrollee's and spouse's name must be listed on the documentation of joint ownership.** Where indicated, proof\* of joint ownership must be dated within the past 90 days. Examples of proof of joint ownership include a copy of:

- Most recent tax return showing "Married Filing Jointly" or "Married Filing Separately". Your spouse's name **must** appear on the tax form on the line after the "Married Filing Separately" status (or vice versa). Submit page 1 of tax return.
- Homeowners/Renters Insurance Policy
- Credit Card Statement\*
- Loan Obligation **or** Bank Account Statement\*
- Pension **or** Life insurance **or** Will, designating your spouse as a beneficiary
- Mortgage Statement **or** Rental/Lease Agreement **or** Property Tax Document\*
- Utility **or** Phone **or** Internet/Cable Bill\*

**If you are not able to provide the required documentation, please complete the Employee/Retiree Affidavit, have it notarized, and return it with your completed enrollment form.**

#### 2. For Children:

For a Natural-Born Child, a copy of:

- Birth Certificate showing retiree's name\*
- Social Security Card

For a Stepchild or Legally Adopted Child, a copy of:

- Birth Certificate\*
- Social Security Card
- Legal documentation concerning adoption/guardianship

**\*Due to Puerto Rico's Birth Certificate Law, Puerto Rican Birth Certificates issued prior to July 1, 2010 are invalid, and will not be accepted.**

#### 3. Dependent Children Between Ages 19 and 26:

Dependent children are eligible for dental coverage up to age 26 regardless of full-time student status.