2026 Open Enrollment

November 1 – November 30, 2025

Health Benefits Summary

MTA New York City Transit Active Employees With NYSHIP Health Plan

MTA Business Service Center
www.mymta.info

CONTENTS

1 INTRODUCTION

Open Enrollment Period: November 1 – November 30

Plan changes will be effective January 1, 2026

Reminder…to remain in your current medical, dental, or vision plan, no action is required.

The Business Service Center (BSC) processes all medical, dental, and vision benefit enrollments and changes. For assistance, contact us at 646-376-0123 or bscservice@mtabsc.org.

During the Open Enrollment period, you may…

- Change your benefits coverage
- Add, change, and/or remove dependents

Available online on My MTA Portal (www.mymta.info/openenrollment)…

- Open Enrollment Recorded Informational Webinars
- Self-service access to change medical, dental, and/or vision plan enrollment
- Summary of Health Benefits
- Medical, dental, and vision enrollment/change forms
- Flexible Spending Account enrollment information
- MTA Medical Opt-Out Program information and enrollment form

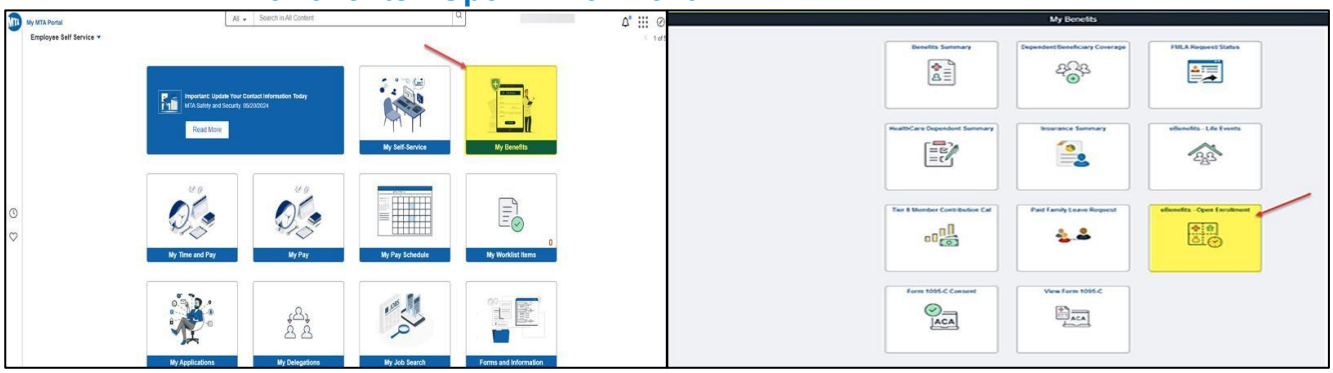
Dates to remember…

You can access information on the MTA Opt-Out and Tax-Favored programs via the BSC website and the provider websites. Go to www.mymta.info/openenrollment.

- **Medical Opt-Out Program: November 1 – November 30**
- Flexible Spending Account (FSA): November 1 – December 15

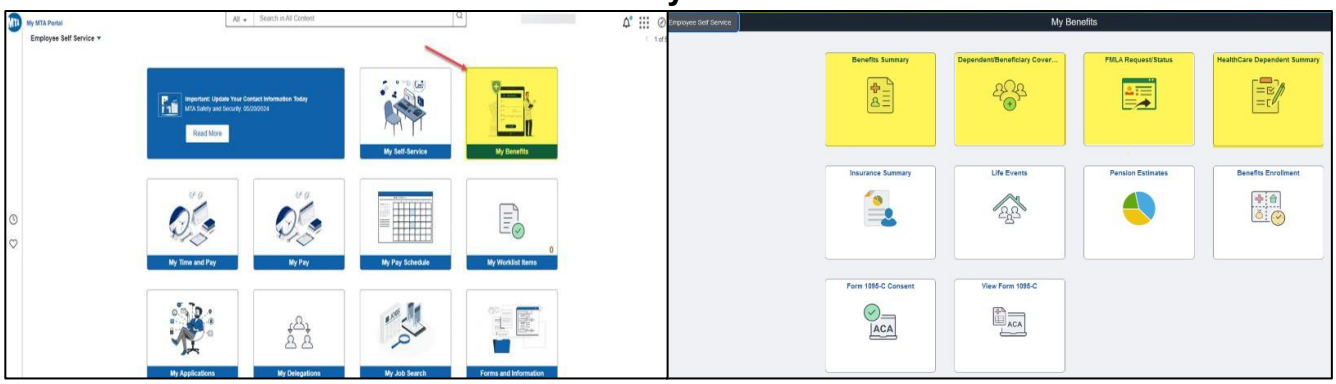
2 HOW TO MAKE CHANGES

- **To make medical, dental, and/or vision plan changes online:**
  - Sign on to the My MTA Portal (www.mymta.info)
  - On the home page, click the **My Benefits** tile, then the **eBenefits - Open Enrollment** tile



- **To make medical, dental, and/or vision plan changes via form and/or to add a *new* dependent, make a change to, or remove a current dependent**, submit the enrollment form(s) below as applicable:
  - **HR-BEN-060K** 2026 NYSHIP Open Enrollment/Change Form
  - **HR-BEN-062** EyeMed Vision Plan Enrollment/Change Form
  - **HR-BEN-849R** Dental Plan Open Enrollment/Change Form for Active NYCT SSSA/TSO Operating & Queens Division/TSO MSII/TSO SSII/MTA Bus TSO Local 106/Special Inspector (UFLEO) Employees with NYSHIP Health Plan
  - **HR-BEN-849S** Dental Plan Open Enrollment/Change Form for Active NYCT/MaBSTOA Represented & Non-Represented Employees with NYSHIP Health Plan
    - Dependent updates **cannot** be submitted online
    - You **MUST** submit the above form(s) if you would like to add/enroll a new dependent, remove/delete a current dependent, *or* make any changes to the biographical information on file for a current dependent
    - *Do **NOT** submit the above form(s) if you are making your medical, dental, or vision coverage changes online*

- **Use online services to review all your benefits information:**



3 HEALTH BENEFIT CHOICES

To assist with your decision-making, please review the **2026 NYSHIP Choices Guide**, which lists all your plan choices. The NYSHIP Choices Guide will be available on the open enrollment website at www.mymta.info/openenrollment in November of this year.

The **2026 Employee Contribution Rates** will be available on the My MTA Portal in December. It will include information on the following options:

- **The Empire Plan Preferred Provider Organization (PPO) Rates**
- **The NYSHIP Approved Health Maintenance Organization (HMO) Rates**

If you elect to make a change, it is important that you choose carefully because you will ***NOT*** be able to change your health insurance option after the ***November 30, 2025*** **open enrollment deadline**, except if the medical plan option you are enrolled in no longer services the area in which you live.

To make changes to your NYSHIP Health Plan enrollment, you **MUST** submit your request online **OR** complete and submit the below form:

- **HR-BEN-060K 2026 NYSHIP Open Enrollment/Change Form**

You are only allowed to change your enrollment status/options outside of the open enrollment period if you experience a qualifying life event during the year, such as marriage, divorce, the birth or adoption of a child, the loss of dependent child status, or the loss of coverage.

If you experience a qualifying life event, you MUST update your MTA records by submitting the appropriate enrollment forms and ALL required supporting documentation to the MTA BSC within thirty-one (31) days of the qualifying event date.

Please note that medical insurance contribution costs to cover you and/or your family are made via payroll deduction on a *pre-tax* basis, while contributions that cover a domestic partner are withheld via payroll deduction on a *post-tax* basis.

NOTE TO ALL EMPLOYEES PLANNING TO RETIRE IN 2026

Upon retirement, if you and/or your covered dependent(s) become Medicare-eligible as a result of reaching at least age 65 *or* becoming disabled, Medicare will be the primary medical coverage for you and/or your Medicare-eligible dependent(s).This will occur on the first of the month **or** the following month coinciding with your Medicare-eligibility date.

Please ensure that you and/or your covered dependent(s) enroll in Medicare.

Enrollment in Medicare generally takes about three months, unless your birthday is the first of any month, in which case, your Medicare eligibility will begin the first of the month that *precedes* your 65th birthday, so please contact the Social Security Administration in advance so that upon retirement, you and/or your dependent will be enrolled in Medicare Part A for hospitalization and Medicare Part B for medical.

Dental benefits eligibility and dental plan options will vary based on your respective union affiliation as detailed below:

- **Active NYCT SSSA,TSO Operating & Queens Division, TSO MSII, TSO SSII, MTA Bus TSO Local 106, and Special Inspector (UFLEO) Employees with the NYSHIP Health Plan** have a choice between the *CIGNA DHMO* or the *CIGNA DPPO* dental plans
    - To make changes to your *dental plan* enrollment, you **MUST** submit your request online **OR** by completing and submitting the **HR-BEN-849R** Dental Plan Open Enrollment/Change Form for Active NYCT SSSA/TSO Operating & Queens Division/TSO MSII/TSO SSII/MTA Bus TSO Local 106/Special Inspector (UFLEO) Employees with NYSHIP Health Plan

- **Active NYCT & MaBSTOA Represented & Non-Represented Employees with the NYSHIP Health Plan** have a choice between the MetLife PPO or the DentCare/HealthPlex dental plans.
    - To make changes to your *dental plan* enrollment, you **MUST** submit your request online **OR** by completing and submitting the **HR-BEN-849S** Dental Plan Open Enrollment/Change Form for Active NYCT/MaBSTOA Represented & Non-Represented Employees with NYSHIP Health Plan

For all other employee groups ***not*** specifically detailed above, dental benefits are available to you and your qualified dependents through MetLife, while vision benefits are available to NYCT active employees enrolled in the *NYSHIP Health Plan* and their eligible dependents, through EyeMed.

4 MTA MEDICAL OPT-OUT PROGRAM

Opt-Out Program for Medical/Hospital and Prescription Drugs…

If you have or will have alternate medical coverage as of the upcoming plan year, you Can take advantage of the MTA's Medical Opt-Out Program. **If you're enrolled in Dental and vision coverage, it will remain in effect even if you participate in the Opt-Out Program.**

General Overview of the Opt-Out Process:

1. **If you previously enrolled in the Opt-Out Program in 2025 and wish to continue in the Opt-Out Program for 2026:**
    - **NO ACTION REQUIRED:** Your opt-out status will remain in place for 2026

2. **If you previously enrolled in the Opt-Out Program in 2025 and wish to *re-enroll* in Medical/Hospital and Prescription Drug Coverage for 2026, you MUST:**
    - Complete the **HR-BEN-060K** 2026 NYSHIP Open Enrollment/Change Form, and submit it to the BSC, by **November 30, 2025**

3. **If you are currently enrolled in Medical/Hospital and Prescription Drug Coverage for 2025 and wish to *enroll* in the Medical Opt-Out Program for 2026, you MUST:**
    - Complete the **HR-BEN-036** Agreement to Decline (Opt-Out) Medical Coverage Non-Represented & Eligible Represented Employees Form, and submit to the BSC, by **November 30, 2025**

4. **If you *"waived"* or *"declined"* Medical/Hospital and Prescription Drug Coverage as a new hire in 2025, and now wish to *enroll* in the Medical Opt-Out Program for 2026, you MUST:**
    - Complete the **HR-BEN-036** Agreement to Decline (Opt-Out) Medical Coverage Non-Represented & Eligible Represented Employees Form, and submit to the BSC, by **November 30, 2025**

    - *Waiving* or *declining* coverage does ***not*** automatically enroll you into the *Opt*-out Program. You **must** actively enroll in the Opt-out Program during this year's annual open enrollment period if you wish to participate.

Additional Information About the Medical Opt-Out Program:

1. To opt-out of medical/hospital and prescription drug coverage, you ***must*** provide proof you have coverage under an alternate medical plan or will have coverage by January 1, 2026

2. **For Active NYCT SSSA employees enrolled in the NYSHIP Health Plan, if you participate in the Medical Opt-Out Program, and separate from MTA service *before* the end of the opt-out year, you will not be eligible to receive any part of the incentive payment**
    - The incentive payments for individual *or* family plan opt-out will be paid in December 2026 **OR** pursuant to the represented employee's collective bargaining agreement
        - **For 2026, the individual opt-out incentive payment is $550**
        - **For 2026, the family opt-out incentive payment is $1,100**

3. **For all other NYCT employee groups enrolled in the NYSHIP Health Plan, inclusive of active NYCT TSO Operating & Queens Division, TSO MSII, TSO SSII, Special Inspector (UFLEO), and MTA Bus TSO Local 106 employees, if you participate in the Medical Opt-Out Program, and separate from MTA service *before* the end of the opt-out year, the incentive payment will be prorated**
    - The incentive payments for individual *or* family plan opt-out will be paid in January 2027 **OR** pursuant to the represented employee's collective bargaining agreement
        - **For 2026, the individual opt-out incentive payment is $1,000**
        - **For 2026, the family opt-out incentive payment is $3,000**

4. If you are a ***non-represented*** employee currently contributing toward your medical coverage, no contributions will be withheld from your 2026 salary if you participate in the Opt-Out Program

5. If you are a ***represented*** employee, contributions during the opt-out period will be subject to the terms of the applicable collective bargaining agreement

6. You have the option to defer the opt-out incentive payment to your 401(k), 457, or Roth accounts
    - To do so, you **MUST** submit the **HR-DEFCOMP-075** Medical Opt-Out Deferred Compensation Lump Sum Deferral form **every year**

7. The incentive payment is subject to all applicable federal, state, and local taxes and is not considered pensionable income (it will not be included in any pension calculations)

8. If you've previously *waived* or *declined* MTA-sponsored health plan coverage and wish to now enroll in the Opt-Out Program for 2026, you **MUST** submit a request to opt-out during your respective open enrollment period this year

9. The election to opt-out remains in effect until you change your election during a future open enrollment period **OR** experience a qualified family status/life event change

5 REQUIRED SUPPORTING DOCUEMNTATION

To add *new* eligible dependent(s) to your MTA-sponsored coverage, you **MUST** submit **REQUIRED** supporting documentation based on your relationship to the eligible dependent.

1. For a Spouse:

A copy of your official governmental (non-religious) Marriage Certificate (religious documents will **not** be accepted), spouse's Birth Certificate, **and** spouse's Social Security Card are **required**.

In place of the required spouse's *Birth Certificate*, either one (1) of the following official government documents can be alternatively submitted:

- Government-issued Photo Identification (ID) Card
- Valid US Passport

AND

If your date of marriage is more than one (1) year old as listed on your official governmental marriage certificate, proof of joint ownership is also REQUIRED.

If your marriage date is less than 1 year old, proof of joint ownership is not required.

Both the employee's and spouse's names MUST be listed on the documentation of joint ownership. Proof of joint ownership **MUST** be dated within the past 90 days. Examples of proof of joint ownership include a copy of:

- Most recent federal or state 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 only page 1 of the 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

To ***remove*** a spouse from your MTA-sponsored coverage due to divorce, you **MUST** submit the first and last page of the divorce decree filed by the County Clerk's Office which shows the court filing date.

You are REQUIRED to notify the MTA BSC of your legal divorce within thirty-one (31) days of the divorce date indicated on the divorce decree.

2. For a Domestic Partner:

To enroll a domestic partner into your MTA-sponsored coverage, in addition to completing and submitting the applicable enrollment/change form(s), you **MUST** also complete and submit the domestic partner application package, **HR-BEN-065**, as well as provide **ALL** the required supporting documentation listed within the domestic partner application package, to the MTA BSC.

The **HR-BEN-065** domestic partner package can be obtained on the My MTA Portal at www.mymta.info *or* by contacting the MTA BSC at 646-376-0123, 8:30am to 5:00pm, Monday through Friday *or* via email at bscservice@mtabsc.org.

3. For Child(ren):

For a natural-born child, a copy of:

- Birth Certificate showing employee'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.**

6 LEGAL REQUIREMENTS

COVERAGE FOR DEPENDENT CHILDREN

A dependent child is eligible for medical, hospital, and prescription drug coverage, regardless of their student or marital status, up to the age of 26.

- To **enroll** a dependent child, aged 19 to 26 in medical coverage, submit the **HR-BEN-060K** 2026 NYSHIP Open Enrollment/Change Form

Submit the open enrollment form detialed above with **ALL** required supporting documentation as detailed in Section 5, and affirm, by signing the form, that your child is eligible for coverage.

SOCIAL SECURITY NUMBER REQUIREMENT

The Medicare, Medicaid, and State Children's Health Insurance Extension Act of 2007 (MMSEA) requires the MTA to report Social Security Numbers to the Federal Centers for Medicare and Medicaid Services (CMS) for all dependents who are at least age 45.

You can check to see if a covered dependent's Social Security Number is missing from your MTA benefits record by signing on to the My MTA Portal at www.mymta.info.

Click on the **My Benefits** tile, then click the **Health Care Dependent Summary** tile. Click the dependent's name to view their personal information.

If a dependent's Social Security Number is not shown under SSN (only the last four digits will show), please submit to the MTA BSC, a copy of the dependent's Social Security Card with your name and BSC ID number noted on the copy, along with the enrollment form listed below.

Be sure to include your name and BSC ID number on the copy of the Social Security Card(s).

- **HR-BEN-060K** 2026 NYSHIP Open Enrollment/Change Form

7 IMPORTANT TELEPHONE NUMBERS & WEBSITES

Medical/Hospital		
NYSHIP	877-769-7447	http://www.cs.ny.gov
Dental		
MetLife	800-942-0854	www.MetLife.com
CIGNA	800-578-5682	www.CIGNA.com
DentCare/HealthPlex	800-468-0600	www.HealthPlex.com
Vision		
EyeMed	866-299-1358	www.EyeMedVisionCare.com
Tax-Favored Programs		
P&A Group (FSA)	800-688-2611	www.padmin.com
Empower (401K/457 Plans)	877-756-4682	www.Empower.com
NY 529 College Savings	877-697-2837	www.NY529AtWork.org
EdenRed (Commuter Benefit)	888-235-9223	www.login.edenredbenefits.com
COBRA		
WEX Health, Inc.	866-451-3399	www.WEXInc.com/login
Federal Government		
Medicare	800-633-4227	www.MyMedicare.gov
Social Security Administration	800-772-1213	www.SSA.gov
Business Service Center		
Phone: 646-376-0123, 8:30a.m. - 5p.m., Monday - Friday Email: bscservice@mtabsc.org Website: www.MyMTA.info ***Please have your BSC ID ready when you call us and be sure to include your full name and BSC ID on all emails and documents submitted.***		

NEW YORK STATE | **Department of Civil Service**
Employee Benefits Division

PS-404 (6/2025)

NYSHIP Health Insurance Transaction Form for NYS & PE Employees
Department of Civil Service, Albany, NY 12239

INSTRUCTIONS: Read and complete both pages. Please print, check the appropriate choices and sign/date the document.

1–12 EMPLOYEE INFORMATION

1. Last Name First Name MI

2. Social Security Number _ _ _ – _ _ – _ _ _ _ **3.** Gender ☐ F ☐ M ☐ X

4. Permanent Address Street City State Zip

5. Mailing Address *(If different)* Street City State Zip

6. Work Address Street City State Zip

7. Date of Birth _ _ / _ _ / _ _ _ _ **8.** Telephone Primary ( ) Work ( )

9. Personal Email Address

10. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Marital Status Date _ _ / _ _ / _ _ _ _

11. Covered under Medicare?
☐ Self Medicare ID Number Date _ _ / _ _ / _ _ _ _
☐ Dependent Dependent Name _____
Medicare ID Number _____ Date _ _ / _ _ / _ _ _ _

12. Is any of this information new? ☐ No ☐ Yes Box Number(s) _____ Effective Date of Change _ _ / _ _ / _ _ _ _

13 ELECT COVERAGE

13A. Choose a Pre-Tax election (**NOT** applicable to MTA employees: ***All*** NYSHIP payroll contributions are *pre-tax* for MTA employees)
You are only eligible for Pre-Tax deductions if newly eligible or if requested during the Pre-Tax Contribution Program (PTCP) Election Period.

1. ☐ **Elect Pre-Tax Status** for Premium deduction **2.** ☐ **Elect After-Tax Status** for Premium deduction

13B. Select a NYSHIP Coverage Option *(You can **ONLY** choose **ONE** option between either 1 or 2 below)*

1. Individual Enrollment (You **MUST** select *Empire Plan* ***or*** an HMO Plan)
☐ Empire Plan ☐ HMO Code _____ HMO Name _____

2. Family Enrollment (**MUST** complete Box 14) (You **MUST** select *Empire Plan* ***or*** an HMO Plan)
☐ Empire Plan ☐ HMO Code _____ HMO Name _____

3. Opt-out Program *You can **ONLY** enroll in the MTA Medical Opt-Out Program during the annual **Open Enrollment Period**. You **MUST** complete the **HR-BEN-036** Agreement to Decline (Opt-out) form **OR** visit the My MTA Portal at **www.mymta.info** to opt out online.*

14 DEPENDENT INFORMATION

This information MUST be provided when choosing to enroll in *or* cancel NYSHIP *family* coverage
*(If more space is needed to list all eligible dependents you would like to enroll/remove, you **must** complete the attached PS-404S form.)* Date of event _ _ / _ _ / _ _ _ _

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update **MUST SELECT:** ☐ Medical

Last Name _____ First Name _____ MI ____ Relationship _____

Date of Birth _ _ / _ _ / _ _ _ _ Gender ☐ F ☐ M ☐ X Social Security Number _ _ _ – _ _ – _ _ _ _

Address *(if different)* _____

☐ If you have additional dependents, please check this box. You **MUST** also complete the attached PS-404S form with their information.

15 NOTIFICATION PREFERENCES

To change how you receive NYSHIP publications, select one option below. If no option is selected, you will continue to receive mail only. A valid personal email is required for email delivery. Some communications must be sent by mail.

☐ I would like to receive publications by email only. ☐ I would like to receive publications by email and mail.

PS-404 (6/2025) • NYSHIP Health Insurance Transaction Form for NYS & PE Employees
Department of Civil Service, Albany, NY 12239

16 CHANGE OR DECLINE/CANCEL COVERAGE

16A. Change Coverage ☐ Medical Date of Event _ _ /_ _ /_ _ _ _

☐ **Change to FAMILY** *(Complete Box 14 on page 1)*	☐ **Change to INDIVIDUAL**
☐ Marriage	☐ Divorce
☐ Domestic Partner	☐ Termination of Domestic Partnership *(Attach completed PS-425.4)*
☐ Newborn	☐ Only dependent ineligible due to age
☐ Request coverage for dependents not previously covered	☐ I voluntarily cancel coverage for my dependents
☐ Previous coverage terminated *(proof required)*	☐ Only dependent died
☐ Other_____	☐ Other_____

NOTE: If indicating a change in marital status due to divorce, separation, or adding/removing a domestic partner, you **MUST** fill-in the dependent's information in Box 14. Final divorce decrees (first & last page with the date filed by the court) are **required** for divorce. If you've married your domestic partner, you **MUST** update your marital status within 31 days.

16B. Voluntarily Decline ***or*** Cancel Coverage ☐ Medical Qualifying Event Date _ _ / _ _ / _ _ _ _

NOTE: Voluntarily declining or canceling your coverage is **NOT** the same as *opting out* of medical coverage and participating in the MTA Medical Opt-Out Program. You **MUST** complete the **HR-BEN-036** Agreement to Decline (Opt-out) Medical Coverage form ***OR*** visit the My MTA Portal at **www.mymta.info** to easily opt out online.

17 ENTER ANNUAL OPTION TRANSFER REQUEST (This section is NOT applicable to MTA Employees)

Change NYSHIP Option — Change to: ☐ Empire Plan ☐ HMO Code _____ HMO Name_____

Elect Opt-out *(NYS Medical Only)* — ☐ Individual Opt-out ☐ Family Opt-out
If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.

Change Pre-Tax Status — Change to: ☐ Pre-Tax ☐ After-Tax *Submit during the PTCP Election Period.*

18 DONATE LIFE REGISTRY ELECTION

You must fill out the following section. This question must be answered each time the form is filled out.

Would you like to be added to the Donate Life Registry? ☐ Yes ☐ Skip this question

By indicating yes in response to the question asking if you would like to be added to the Donate Life Registry, you are certifying that you are 16 years of age or older, consenting to donate your organs and tissues for the purposes of transplantation and research in the event of your death and authorizing NYSHIP to share your name and identifying information with the Registry.

ID Number on New York State Driver License, Learner Permit, or Non-Driver ID Card _____

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

The information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

AUTHORIZATION

This authorization is made now for future deductions that will occur at the time of retirement. Pursuant to the following Sections of NYS Retirement and Social Security Law: 110-a; 110-b; 110-c; 110-d; 410-a; 410-b or 410-c, I hereby authorize the NYS Department of Civil Service (DCS) to deduct an amount from my monthly retirement allowance from the New York State and Local Retirement Systems (NYSLRS) to cover any deductions for insurance premiums payable on behalf of DCS. Authorization is given to make any future adjustment deductions and/or changes DCS certifies to NYSLRS as necessary in the amount of such insurance premiums. I understand that all requests to begin, modify, or revoke deductions must be submitted to my current/former agency and provided to DCS. This authorization shall remain in effect until revoked by me by written notice or until otherwise revoked pursuant to law.

I understand that if my coverage is declined or canceled, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date and may forfeit the right to such coverage after leaving State service (vest, retirement, etc.). I am aware of how to obtain a current *Summary of Benefits and Coverage* for the NYSHIP option I have selected. I understand that my failure to provide required proof(s) within 30 days may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims.

I certify that the information I have supplied is true and correct. I hereby authorize deduction from my salary or retirement allowance of the amount required, if any, for the coverage indicated above.

▶ **Employee Signature (Required)** _____ **Date** _ _ / _ _ / _ _ _ _

AGENCY USE ONLY

Retirement Tier	Registration #	Sick Leave Information		Date Entered on NYBEAS	Effective Date
		# Hours	Hourly Rate of Pay		

▶ **HBA Signature (Required)** _____ **Date** _ _ / _ _ / _ _ _ _

NEW YORK STATE | **Department of Civil Service**
Employee Benefits Division

PS-404 Instructions (6/2025)

NYSHIP Health Insurance Transaction Form for NYS & PE Employees

Department of Civil Service, Albany, NY 12239

NYSHIP PROGRAM INFORMATION RESOURCES

To enroll in benefits or to change your current benefits, you will most likely be required to submit proofs of eligibility for coverage or evidence of a qualifying event with the completed and signed *NYSHIP Health Insurance Transaction Form* PS-404. Learn more about these additional requirements in the following publications:

- ***General Information Book (GIB)***
  Eligibility, enrollment, required forms and proofs of eligibility
- ***Choices***
  Your plan options under NYSHIP (Empire Plan, NYSHIP HMO or the Opt-out Program) and the benefits included with each one

In many situations, you will also be required to complete, sign and submit additional forms and proofs. For detailed instructions on what will be required, please refer to your *GIB* and any additional forms and form instructions for requirements specific to your request.

Please return this completed form and **ALL** required supporting documentation to the MTA Business Service Center (BSC) via email at **bsc-benefits@mtabsc.org**.

EMPLOYEE INFORMATION

Boxes 1–12	Employee Information	You must complete Boxes 1–11 with your personal information. In Box 12, indicate if any of the information in Boxes 1–11 is new and needs to be updated on your NYSHIP record. Please also indicate which of the boxes contains updated information and a date of the change (if applicable). **NOTE:** Use the Marital Status Date field to show the date of marriage, separation, or divorce when any of those marital statuses are selected. You **MUST** advise the MTA BSC of *any* changes in your marital status within 31 days of the change **and** provide supporting documentation of the marital status change as required.

ELECT COVERAGE

NOTE: If you choose a NYSHIP HMO, the HMO may require you to complete an additional enrollment form.

Box 13A	Pre-Tax Contribution Program (PTCP) Status	**This section is NOT applicable to MTA employees as the MTA is a Participating Employer (PE). For MTA employees enrolled in NYSHIP coverage and who have deductions taken from their paychecks to pay for their NYSHIP coverage, these deductions will *always* be pre-tax.** A NYS enrollee can only elect to enroll in Pre-Tax Status when first eligible for coverage or during the PTCP Election Period which coincides with the annual Option Transfer Period. All elections to Pre-Tax Status made outside these designated times or failure to make an election will automatically default to Post-Tax. If you work for a Participating Employer (PE), contact your HBA for eligibility.
Box 13B	NYSHIP Plan Option	If you choose an HMO, you can find the 3-digit code in the *Health Insurance Choices* or *NYSHIP Rates & Deadlines* publications. **REMINDER:** Enrollees with an Employee Benefit Fund (CSEA, DC-37, UCS, and UUP) receive their dental and vision benefits through that fund. If you are a member of one of these groups, you may not enroll for NYSHIP dental or vision benefits (this does ***NOT*** apply to MTA employees).
Box 13B 1	Individual Enrollment	Check box to enroll in Individual coverage. Check Medical box for coverage selected.
Box 13B 2	Family Enrollment	Check box to enroll in Family coverage. Check Medical box for coverage selected.
Box 13B 3	Elect the Opt-out Program	To participate in the MTA Medical Opt-Out Program, do **NOT** complete this form. You **MUST** instead visit the **My MTA Portal** to opt out online ***OR*** complete the **HR-BEN-036 Agreement to Decline (Opt-out) Medical Coverage Non-Represented & Eligible Represented Employees** form during your annual Open Enrollment Period.

2026 NYSHIP Open Enrollment/Change Form
HR-BEN-060K

PS-404 (6/2025) Instructions • NYSHIP Health Insurance Transaction Form for NYS & PE Employees
Department of Civil Service, Albany, NY 12239

DEPENDENT INFORMATION

Box 14	Dependent Information	Check the box to add or remove a dependent or to update a dependent's information. If a dependent was previously removed and is now being added, also check the update box if there have been any changes to that dependent's information. Complete all dependent information and provide the dependent's Social Security Number. Additional documentation is required to add the dependent.

NOTIFICATION PREFERENCES

Box 15	Notification Preferences	To change how you receive NYSHIP publications, check one of the boxes in this section. If you check "I would like to receive publications by email only," you will stop receiving NYSHIP publications by mail. Some required communications may still be mailed. If you check "I would like to receive publications by email and mail," you will receive NYSHIP publications by email and mail. **A valid personal email address must be provided in Box 9 to receive publications by email.** If you do not check a box, you will continue to receive publications by mail only.

CHANGE IN COVERAGE OR VOLUNTARILY CANCEL COVERAGE

Box 16A	Change Coverage	Select the *Change to FAMILY* box if you are currently enrolled in individual coverage but are adding eligible dependent(s) ***or*** the *Change to INDIVIDUAL* box if you are removing *all* dependents. Select the reason for the change, or *other* if none of the boxes apply. You ***MUST*** notify the MTA BSC within 31 days of *any* marital status changes. If you are indicating a change in your marital status to *divorced* or *separated*, update the dependent's new address, if applicable, in the Dependent Information section (Box 14). Final divorce decrees (first and last page) are ***required***. *Expected* court appearances or other documents will **not** be accepted. If your domestic partner is now your spouse, you ***MUST*** provide a copy of your *non-religious* marriage certificate ***and*** this duly completed NYSHIP enrollment form.
Box 16B	Voluntarily Cancel Coverage	You are only entitled to voluntarily **Decline/Waive** MTA-sponsored NYSHIP coverage if you are a newly hired employee ***OR*** are promoted into a NYSHIP-eligible role/title. You are only eligible to voluntarily **Cancel** your current MTA-sponsored NYSHIP coverage if you experience a qualifying life event ***OR*** during your respective annual open enrollment period.

ANNUAL OPTION TRANSFER REQUEST (This section is NOT applicable to MTA Employees)

Box 17	Annual Option Transfer Request(s)	**CHANGE NYSHIP OPTION:** Complete to make an option change during the annual Option Transfer Period. **ELECT OPT-OUT:** Enrollees electing the Opt-out Program must complete a PS-409, *Opt-out Attestation Form*. If you are selecting Family Opt-out, you must have been enrolled in NYSHIP Family coverage beginning April 1 of the current plan year or within 30 days of a change to Family coverage after a qualifying event. See your HBA or your plan materials for additional eligibility requirements. **CHANGE PRE-TAX STATUS:** Existing enrollees can only change PTCP status during the annual PTCP Election Period, which coincides with the annual Option Transfer Period. If you work for a Participating Employer (PE), contact your HBA for eligibility.

DONATE LIFE REGISTRY ELECTION

Box 18	Donate Life Registry Election	**DONATE LIFE REGISTRY:** Check box for 'Yes' or 'Skip this question.' **This question must be answered each time the form is filled out.** If you check the box marked 'Yes', you are indicating your consent to enroll in the Donate Life Registry. You understand that by enrolling in the Registry, you are giving legal consent to the donation of your organs, tissues and eyes in the event of your death. You authorize access to the information as needed for the administration of the Registry and to federally regulated organ procurement organizations, New York State licensed tissue and eye banks, and entities formally approved by the NYS Commissioner of Health at or near the time of your death. **NYS DMV ID:** If you check the 'Yes' box, it is recommended that you provide an ID number from your New York State Driver License, Learner Permit, or Non-Driver ID card. If you check the 'Skip this question' box, skip this section.

AUTHORIZATION

YOU MUST SIGN AND DATE THIS FORM.

NEW YORK STATE | **Department of Civil Service**
Employee Benefits Division

PS-404S (6/2025)
NYSHIP Health Insurance Transaction Form
Additional Dependent Information Supplement
Department of Civil Service, Albany, NY 12239

INSTRUCTIONS: Only complete this page along with the PS-404 form (also known as the HR-BEN-060A) if you need to include information for additional eligible dependents you would like to enroll in or remove from coverage.

EMPLOYEE INFORMATION

Last Name First Name MI

DEPENDENT INFORMATION

NOTE: This information MUST be provided when choosing to enroll in or cancel NYSHIP *family* coverage.

Date of event __ / __ / ____

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update **PLEASE SELECT:** ☐ Medical

Last Name ________ First Name ________ MI ____ Relationship ________

Date of Birth __ / __ / ____ Gender ☐ F ☐ M ☐ X Social Security Number ___ – __ – ____

Address *(if different)* ________

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update **PLEASE SELECT:** ☐ Medical

Last Name ________ First Name ________ MI ____ Relationship ________

Date of Birth __ / __ / ____ Gender ☐ F ☐ M ☐ X Social Security Number ___ – __ – ____

Address *(if different)* ________

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update **PLEASE SELECT:** ☐ Medical

Last Name ________ First Name ________ MI ____ Relationship ________

Date of Birth __ / __ / ____ Gender ☐ F ☐ M ☐ X Social Security Number ___ – __ – ____

Address *(if different)* ________

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update **PLEASE SELECT:** ☐ Medical

Last Name ________ First Name ________ MI ____ Relationship ________

Date of Birth __ / __ / ____ Gender ☐ F ☐ M ☐ X Social Security Number ___ – __ – ____

Address *(if different)* ________

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update **PLEASE SELECT:** ☐ Medical

Last Name ________ First Name ________ MI ____ Relationship ________

Date of Birth __ / __ / ____ Gender ☐ F ☐ M ☐ X Social Security Number ___ – __ – ____

Address *(if different)* ________

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update **PLEASE SELECT:** ☐ Medical

Last Name ________ First Name ________ MI ____ Relationship ________

Date of Birth __ / __ / ____ Gender ☐ F ☐ M ☐ X Social Security Number ___ – __ – ____

Address *(if different)* ________

EyeMed Vision Plan Enrollment/Change Form

HR-BEN-062

Section 1 - Information & Instructions

Complete this form to enroll in **or** change your EyeMed vision coverage. This form is only for active employees and/or their dependent(s) who are eligible for the EyeMed Vision Plan.

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 **must** be submitted via fax to 212-852-8700 **OR** via email to bsc-benefits@mtabsc.org for processing.

If you have questions, you must call the Business Service Center (BSC) at 646-376-0123, 8:30AM - 5:00PM, Monday to Friday, **OR** email bscservice@mtabsc.org.

Section 2 - Employee Information

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

IMPORTANT REMINDER: Your health insurance cards will be mailed to the address on your pay stub. If your address is incorrect, you **must** log onto **www.mymta.info** to update your address or to obtain the *HR-HRIS-012 Employee Data Change Form*. An incorrect address will delay receipt of health insurance cards and other important benefits-related information.

Section 3 - Vision Coverage Elections

Election Type: ☐ New Enrollment ☐ Reinstatement

Coverage Level: ☐ Individual ☐ Family

Change of Status: ☐ Add Dependent ☐ Remove Dependent

WAIVE VISION COVERAGE

☐ **I DO NOT wish to enroll in MTA-Sponsored Vision Coverage*****

***Your election to waive coverage will remain in effect until you change your election during a future open enrollment period *or* if you experience a qualifying life event, such as marriage, birth, divorce, or loss of alternate medical coverage, during the year. Please contact the MTA BSC at 646-376-0123 for additional assistance.**

Section 4 - Dependent Information

ADD, REMOVE, OR CHANGE DEPENDENT(S):

Please complete all information for dependents you wish to add (enroll), remove (delete), or change. The required supporting documentation (see Section 6 of this form) is only required if you are adding a new dependent, removing a spouse due to divorce, or changing a current dependent's biographical information. Use a separate sheet if more space is needed to list additional dependents.

For Divorce: Supporting documentation is **required** within thirty-one (31) days of the divorce date in order to remove an ex-spouse from coverage.

If you are found to be covering an ineligible dependent, coverage will be terminated retroactive to the date of the ineligibility and financial restitution for claims and/or premiums paid for the ineligible dependent(s) will be pursued.

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 MTA-sponsored coverage unless a Domestic Partner Package is submitted and approved by the Benefits Department.

Indicate (A) Add, (R) Remove, or (C) Change					Relationship (Check only ONE)			Date of Birth		
A	R	C	Full Name (First, M.I., Last)	Social Security #	Spouse	Domestic Partner^	Child	MM	DD	YYYY

Section 5 - Signature & 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 all dependent children I have enrolled, including those aged 19 to 26, are eligible for MTA-sponsored coverage.

I understand that if my coverage is waived, I may subject myself and/or my dependents to a waiting period if I decide to enroll at a later date.

Employee Signature:	**Date:**

EyeMed Vision Plan Enrollment/Change Form

HR-BEN-062

Section 6 - Required Supporting Documentation

1. **For a Spouse:**
   A copy of your official governmental (non-religious) Marriage Certificate (religious documents will **not** be accepted), spouse's Birth Certificate, and spouse's 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
   - 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 filed by the County Clerk's Office.

   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*****

2. **For Children:**
   For a Natural-Born Child, a copy of:
   - Birth Certificate showing employee'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.**

Dental Plan Open Enrollment/Change Form

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

HR-BEN-849R

Section 1 - Information and Instructions

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

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

Do **NOT** submit this form if you are making your dental plan enrollment/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 **must** be submitted via fax to 212-852-8700 **OR** via email to bsc-benefits@mtabsc.org for processing.

If you have questions, you must call the Business Service Center (BSC) at 646-376-0123, 8:30AM - 5:00PM, Monday to Friday **OR** email bscservice@mtabsc.org.

Section 2 - Employee Information

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

Please log onto www.mymta.info to confirm your mailing address is accurate *or* to obtain the *HR-HRIS-012 Employee Data Change Form* if an address update is needed. An incorrect address will delay receipt of insurance cards and important benefits-related information from benefits carriers.

Section 3 - Dental Coverage Election (Effective January 1, 2026)

DENTAL: Individual ☐ Family ☐

Check only **ONE** of the below dental plans. Dependent children, regardless of full-time student status, are eligible for dental coverage under the ***CIGNA*** dental plans through the end of the month they attain age 26:

☐ **CIGNA DHMO Dental** ☐ **CIGNA DPPO Dental**

Section 4 - Dependent Information

ADD, REMOVE, OR CHANGE DEPENDENT(S):

Please complete all information for dependents you wish to add (enroll), remove (delete), or change. The required supporting documentation (see Section 6 of this form) is only required if you are adding a new dependent, removing a spouse due to divorce, or changing a current dependent's biographical information. Use a separate sheet if more space is needed to list additional dependents.

For **Newborns:** Supporting documentation is **required** within ninety (90) days of a newborn's birth to remain enrolled in MTA-sponsored benefits. Failure to provide all required documentation within this timeframe will result in the retro-termination (to date of birth) of the newborn from your health coverage.

For **Divorce:** Supporting documentation is **required** within thirty-one (31) days of the divorce date to remove an ex-spouse from health coverage.

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 paid 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 health 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 enrollment/change form along with the **required** NYCT Termination of Domestic Partnership Form.

Indicate (A) Add, (R) Remove, or (C) Change					Relationship (Check only ONE)			Gender			Date of Birth		
A	R	C	Full Name	SSN	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 all dependent children I have enrolled, including those aged 19 to 26, are eligible for MTA-sponsored coverage.

Employee Signature:	**Date:**

Dental Plan Open Enrollment/Change Form

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

HR-BEN-849R

Section 6 - Required Supporting Documentation

1. **For a Spouse:**
   A copy of your official governmental (non-religious) Marriage Certificate (religious documents will **not** be accepted), spouse's Birth Certificate, and spouse's 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
   - 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 filed by the County Clerk's Office.

   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*****

2. **For Children:**
   For a Natural-Born Child, a copy of:
   - Birth Certificate showing employee'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.**

Dental Plan Open Enrollment/Change Form

For Active NYCT/MaBSTOA Represented & Non-Represented Employees with *NYSHIP Health Plan*

HR-BEN-849S

Section 1 - Information and Instructions

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

This form is only for Active NYCT and MaBSTOA Represented and Non-Represented employees and/or their dependents enrolled in or eligible for the **NYSHIP Health Plan**.

Do **NOT** submit this form if you are making your dental plan enrollment/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 **must** be submitted via fax to 212-852-8700 **OR** via email to bsc-benefits@mtabsc.org for processing.

If you have questions, you must call the Business Service Center (BSC) at 646-376-0123, 8:30AM - 5:00PM, Monday to Friday **OR** email bscservice@mtabsc.org.

Section 2 - Employee Information

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

Please log onto www.mymta.info to confirm your mailing address is accurate *or* to obtain the *HR-HRIS-012 Employee Data Change Form* if an address update is needed. An incorrect address will delay receipt of insurance cards and important benefits-related information from benefits carriers.

Section 3 - Dental Coverage Election (Effective January 1, 2026)

DENTAL: Individual ☐ Family ☐

Check only **ONE** of the below dental plans. For dependent children aged 19-25, full-time student verification is **required** and **MUST** be submitted to the MTA BSC *every semester* to maintain dental and vision coverage:

☐ **MetLife PPO** ☐ **DentCare/HealthPlex**

Section 4 - Dependent Information

ADD, REMOVE, OR CHANGE DEPENDENT(S):

Please complete all information for dependents you wish to add (enroll), remove (delete), or change. The required supporting documentation (see Section 6 of this form) is only required if you are adding a new dependent, removing a spouse due to divorce, or changing a current dependent's biographical information. Use a separate sheet if more space is needed to list additional dependents.

For **Newborns:** Supporting documentation is **required** within ninety (90) days of a newborn's birth to remain enrolled in MTA-sponsored benefits. Failure to provide all required documentation within this timeframe will result in the retro-termination (to date of birth) of the newborn from your health coverage.

For **Divorce:** Supporting documentation is **required** within thirty-one (31) days of the divorce date to remove an ex-spouse from health coverage.

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 paid 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 health 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 enrollment/change form along with the **required** NYCT Termination of Domestic Partnership Form.

Indicate (A) Add, (R) Remove, or (C) Change					Relationship (Check only ONE)			Gender			Date of Birth		
A	R	C	Full Name	SSN	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 all dependent children I have enrolled, including those aged 19 to 26, are eligible for MTA-sponsored coverage.

Employee Signature:	**Date:**

Dental Plan Open Enrollment/Change Form

For Active NYCT/MaBSTOA Represented & Non-Represented Employees with *NYSHIP Health Plan*

HR-BEN-849S

Section 6 - Required Supporting Documentation

1. **For a Spouse:**
   A copy of your official governmental (non-religious) Marriage Certificate (religious documents will **not** be accepted), spouse's Birth Certificate, and spouse's 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
   - 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 filed by the County Clerk's Office.

   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*****

2. **For Children:**
   For a Natural-Born Child, a copy of:
   - Birth Certificate showing employee'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.**

Agreement to Decline (Opt-Out) Medical Coverage
Non-Represented and Eligible Represented Employees

HR-BEN-036

Section 1 - Information and Instructions

The purpose of this form is to decline MTA sponsored benefits coverage. Unless otherwise stated, the MTA Business Service Center (BSC) will assume that each year you would like to continue your opt-out agreement, and will never request this form again. If you wish to enroll in MTA Benefits coverage during any point of your tenure with the MTA, you will only be able to do so during the open enrollment period, or a qualifying life event.

Please email completed form to bscservice@mtabsc.org.or fax to 212-852-8700.

If you have any questions, please contact the Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

Section 2 - Employee Information

Print Name	Last		First		M.I. Suffix	BSC ID
Agency/Dept. (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ NYCT	Department
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ MABSTOA	
Street Address						
City					State	Zip Code
Phone (H)			Phone (W)			Email

Section 3 – Incentive Selection

*Select the option that will be applicable for the entire year of **20**____*

INITIAL YOUR SELECTION

☐ I am an employee who receives medical coverage through my spouse/domestic partner who is also employed by the Metropolitan Transportation Authority or another MTA agency, and I, therefore, decline health coverage. Incentive for this option is **$1,000 or $550**. Payment will occur after the end of the plan year.

☐ I am an employee without dependent(s) declining individual coverage. Incentive for this option is **$1,000 or $550**. Payment will occur after the end of the plan year.

☐ I am an employee with dependent(s) declining family coverage. Incentive for this option is **$3,000 or $1,100**. Payment will occur after the end of the plan year.

Note: If you have previously waived coverage or you do not currently have dependent coverage, you must provide documentation for dependents in order to opt out of family coverage. See the enrollment form for details.

Section 4 – Medical Coverage Information

*Provide the information relative to the medical plan that you will be enrolled in for the year **20**____*

Name of Insurance Company:	Plan Sponsor (Employer):
Name of Policyholder:	Relationship:

Section 5 – Medical Coverage Information

I understand that this election will be effective from January 1 through my tenure with the MTA, unless I am no longer allowed by law or as a result of a qualifying event or such other events as the Authority determines will permit a change or revocation of an election. I understand that the lump sum payment will be subject to all applicable federal, state and local taxes. I also understand that these monies will not be considered income for pension purposes and will not be included in any calculation therein.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S PLAN, AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION AGREEMENT RELATING TO SUCH PLAN. THE HEALTH BENEFITS WAIVER WILL BE ADMINISTERED AS PERMISSIBLE UNDER IRC SECTION 125.

Employee Signature	Date	SSN Last 4 Digits

2026 Medical Opt-Out Lump Sum Deferral Form

HR-DEFCOMP-075

Section 1 - Information and Instructions

This form is for the **2026** Opt-Out Program. **It must be completed each year**. Medical Opt-Out deferral elections do not carry over year-to-year. Non-represented employees will be paid in **January 2027**; represented employees will be paid in **December 2026** or pursuant to your collective bargaining agreement.

The Medical Opt-Out payment will be included in your regular paycheck and will not be a separate paycheck. If you elect to defer money from your Medical Opt-Out payment into your 401(k) or 457 Plan, you will need to elect a dollar amount that includes both the amount you want withheld for the medical opt-out payment as well as your regular deferral.

THE AMOUNT ELECTED BELOW WILL BE SET UP TO OVERRIDE YOUR REGULAR DEDUCTION, SO PLEASE TAKE THAT INTO CONSIDERATION WHEN MAKING YOUR ELECTION.

FOR EXAMPLE, IF YOU REGULARLY DEFER $100 FROM YOUR WEEKLY OR BI-WEEKLY PAY INTO YOUR 401(K) PLAN, AND YOU WANT TO DEFER $1,000 FROM THE MEDICAL OPT-OUT PAYMENT, YOUR ELECTION ON THIS FORM WOULD NEED TO BE $1,100.

Also note that that FICA taxes are required to be withheld from your full gross payment even if you are electing to defer into the 401(k)/457 Plans. 401(k) and 457 deferrals are only pre-tax for federal and state tax purposes.

Submit this form to the MTA Business Service Center: Email (preferred): bscservice@mtabsc.org; Fax: 212-852-8700. If you have any questions, please contact the BSC at 646-376-0123.

Section 2 - Employee Information

Print Name	Last		First		M.I. Suffix	BSC ID
Agency/Dept. (check one)	☐ BSC	☐ B&T	☐ C&D	☐ HQ	☐ Police	Department
	☐ SIR	☐ MNR	☐ MTA Bus	☐ NYCT	☐ MaBSTOA	
Street Address						
City				State		Zip Code
Phone (H)		Phone (W)		Email		

Section 3 – Allocation to Deferred Compensation Plans

	Fixed Dollar Amount ($)
401(k) Plan	
401(k) Roth Plan	
457 Plan	
457 Roth Plan	

Section 4 - Authorization

I authorize the MTA to reduce my medical opt-out lump sum payment by the deferral amounts listed above. I understand that these deferrals are subject to IRS limits for each calendar year and that this payment is a part of my W-2 wages and therefore subject to certain required tax withholdings as described in Section 1 of this form. Finally, I acknowledge that this signed form must be received by the MTA ***at least one month prior to the date the medical opt out will be paid****. Forms signed or received after the payment has been made will not be honored*

Employee Signature:	Date:	SSN Last 4 Digits