Catastrophe Major Medical Plan
Enrollment Form

Sponsored by NYSUT Member Benefits Catastrophe Major Medical (CMM) Insurance Trust

Group Policy CMMI-003

OPEN ENROLLMENT PERIOD:
SEPTEMBER 8, 2023 – OCTOBER 13, 2023

COVERAGE EFFECTIVE: JANUARY 1, 2024

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 October 13, 2023 to:

   AMBA
   PO Box 9186
   Des Moines, IA 50306

Questions? **Call AMBA at 888-386-9788.**

Section 1: NEW COVERAGE ELIGIBILITY

1. Are you currently employed in a position where you are represented for purposes of collective bargaining by a NYSUT Affiliate?
   ☐ Yes ☐ No
2. Are you covered by or insured under a Basic Plan (see the definition)?
   ☐ Yes ☐ No

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

Section 2: MEMBER INFORMATION

NYSUT ID#	Date of Birth	
Last	First	MI
Street Address	Apartment	Marital Status
City	State	Zip
Phone(s) _____(Primary) _____(Alternate)	E-mail	

For Office Use Only
NYSUT PD 52898/52899/1002/54736 UFT PD 52904/52905/1002/54736 NYSUT/UFT DB 52906/52907/1002/54736
NYSUT/UFT Adding Dependents Only 1002/54736

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, 2023 to be enrolled.

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

Name (First, Middle Initial, Last)		
Spouse/Domestic Partner:	Date of Birth:	Are they covered by or insured under a Basic Plan? ☐ Yes ☐ No
Child:	Date of Birth:	Are they covered by or insured under a Basic Plan? ☐ Yes ☐ No
Child:	Date of Birth:	Are they covered by or insured under a Basic Plan? ☐ Yes ☐ No
Child:	Date of Birth:	Are they covered by or insured under a Basic Plan? ☐ Yes ☐ No
Child:	Date of Birth:	Are they covered by or insured under a Basic Plan? ☐ Yes ☐ No

Section 4: PAYMENT INFORMATION

NEW ENROLLEES: Select your mode of payment:

☐ **Payroll Deduction** (Please complete the enclosed Payroll Deduction Authorization)
Payroll deductions will begin in January 2024.

☐ **Direct Bill Semi-Annually**
An invoice will be sent to you in November 2023 for the premiums due for 1/1/24 – 6/30/24.
NOTE: Enrollment will not be complete and coverage will not begin unless payment is received by 12/31/2023.

PARTICIPANTS ADDING DEPENDENTS: Your current payment method will not change with the addition of a dependent. If you wish to change your payment information contact AMBA at 888-386-9788.

Section 5: READ, SIGN AND DATE

I understand that coverage shall become effective **January 1, 2024.**

NEW ENROLLEES:
I understand that this plan requires that:

1. 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
2. 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: AMBA, PO Box 9186, Des Moines, IA 50306

IMPORTANT: SUBMISSION MUST BE POSTMARKED BY October 13, 2023

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, Medicaid, a State Children's Health Insurance Plan (CHIP), or TRICARE.

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 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 depends 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 ***nysutmbteinsurance.com*** and clicking "Catastrophe Major Medical Plan" or by contacting AMBA, the Administrator, at 888-386-9788.

New Enrollees

▼ Return the payroll deduction authorization with your enrollment form if electing payroll deduction. ▼

NYSUT MEMBER BENEFITS PAYROLL DEDUCTION AUTHORIZATION FORM

NYSUT Member Benefits Trust NYSUT Member Benefits Corporation NYSUT Member Benefits CMM Insurance Trust

Last Name_____First_____Middle Int._____

Full Address_____

Phone ( ) _____ NYSUT ID# (seven-digit) _____

Authorization is for_____ Soc. Sec. #_____
(Name of plan/insurance – e.g., Term Life Ins., Auto Ins., etc.) (Employee's/Member's SS# - **required**)

Please check your local union membership affiliation: UFT_ _ UUP_ _ PSC/CUNY _ _ All other NYSUT Locals_ _

I hereby authorize my employer to deduct from each of my salary checks the deductions necessary for the purpose of NYSUT Member Benefits. Depending on the NYSUT Member Benefits program(s) which I am enrolled in and that deductions are taken for, monies will be forwarded to the appropriate Plan Administrator. For insurance plans, I understand that this authorization may be revoked at any time by written notice to the Plan Administrator. For plans with annual fees, I understand that I must provide written notice to the Plan Administrator to cancel automatic renewal and that I must satisfy the annual fee.

Signature of Employee (required)_____ Date (required) _____

Send this completed form to the appropriate Plan Administrator along with your application or invoice as indicated.