Dear New Employee:

Welcome to BMCC. Attached are a variety of documents concerning your appointment to the college that you need to be aware of or must complete. Please read these materials carefully and provide all of the requested information as quickly as possible.

We hope you will enjoy your experience at the college. Best wishes for a productive and successful career at BMCC.

Sincerely,

Robert E. Diaz
Vice President for Legal Affairs and Faculty & Staff Relations

/kb/
REQUEST FOR GROUP LIFE AND LONG TERM DISABILITY BENEFITS INSURANCE

<table>
<thead>
<tr>
<th>Name of Employee</th>
<th>Social Security No.</th>
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<td>(Last) (First) (Middle Initial)</td>
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</table>

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<thead>
<tr>
<th>Name of Employer</th>
<th>Date of Birth Mo. Day Yr.</th>
<th>Date Employed in an Eligible Title Mo. Day Yr.</th>
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</thead>
<tbody>
<tr>
<td>THE CITY UNIVERSITY OF NEW YORK</td>
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<thead>
<tr>
<th>Name of College</th>
<th>Basic Annual Salary</th>
<th>□ MALE</th>
<th>□ FEMALE</th>
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</table>

I HEREBY REQUEST THE ISSUANCE OF THE INSURANCE TO WHICH I AM NOW ENTITLED, OR TO WHICH I MAY BECOME ENTITLED, UNDER THE TERMS OF THE GROUP LIFE AND LONG TERM DISABILITY BENEFITS POLICIES ISSUED TO MY EMPLOYER BY TEACHERS INSURANCE AND ANNUITY ASSOCIATION OF AMERICA.

I DESIGNATE THE BENEFICIARY SHOWN ON THE REVERSE SIDE OF THIS FORM TO RECEIVE ANY DEATH BENEFITS WHICH MAY BECOME PAYABLE UNDER THE GROUP LIFE INSURANCE POLICY.

<table>
<thead>
<tr>
<th>Date Signed Mo. Day Yr.</th>
<th>Signature of Employee</th>
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</table>

I have received information on the Group Insurance program.

<table>
<thead>
<tr>
<th>Employee Initials</th>
<th>Date Mo. Day Yr.</th>
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</table>

TO BE COMPLETED BY EMPLOYER

<table>
<thead>
<tr>
<th>Group No.</th>
<th>Effective Date of Life Ins. (Month, Day, Year)</th>
<th>Initial Amt. of Life Insurance.</th>
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<tr>
<td>E-2111</td>
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</table>

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<tr>
<th>Group No.</th>
<th>Effective Date of Disability Ins. (Month, Day, Year)</th>
<th>Certificate No.</th>
</tr>
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<tbody>
<tr>
<td>D-2111</td>
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</table>
GROUP LIFE BENEFICIARY DESIGNATION

Primary Beneficiary(ies) (Class I):
Name and Address
Relationship to Me

Contingent Beneficiary(ies) (Class II), if any:
Name and Address
Relationship to Me

Order of Payment and Division of Benefits. Unless otherwise provided:
(a) payment at my death is to be made to a Beneficiary if he is then living and if there is no Beneficiary in a prior Class living;
(b) if a Class of Beneficiaries contains more than one person, the benefits due the Beneficiaries in such Class at my death are to be apportioned in equal shares to the living Beneficiaries in the Class;
(c) if all Beneficiaries predecease me, the benefits will be payable to my estate.

Definition of Terms. Unless otherwise provided, these terms have the meanings indicated:

CHILDREN: the children born of any and all marriages and any children legally adopted at any time.

ESTATE: my duly appointed Executors or Administrators.

<table>
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<tr>
<th>DATES OF BENEFICIARY CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>
CURRICULUM VITAE INSTRUCTIONS

The CV template follows.

ALL ENTRIES MUST BE TYPED

1. Enter date to the right of "CURRICULUM VITAE".

2. RECOMMENDATION FOR: Check (X) appropriate category, e.g., appointment, reappointment with tenure, promotion, etc.

3. TITLE: Enter title (rank). If reappointment in #2 above, enter current title, if appointment or promotion, enter title to which you wish to be appointed or promoted. Note: There is no tenure in the Instructor title. The fifth reappointment of an instructor becomes an appointment as Lecturer with certificate of continuous employment (CCB).

4. EFFECTIVE DATE: For tenure and promotion: September 1st of the year following the application. For appointment, September 1st or February 1st, as appropriate.

5. HIGHER EDUCATION:
   (A) Degrees: Enter degrees actually conferred. Do not enter progress toward degree. Do not enter certificates or licenses.
   (B) Additional Higher Education and/or Education in Progress: Enter courses and total credits earned toward degrees not yet completed. Enter certificates or licenses.

6. EXPERIENCE:
   (A) Teaching: Enter teaching positions only. Enter in reverse chronological order. Single line entries, e.g., BMCC - 1990 to present - Instructor to Assoc. Prof. - Department.
   (B) Other: Enter non-teaching experience. BMCC Counselors enter single line entries here as per 6, A. above.

7. ACADEMIC AND PROFESSIONAL HONORS: Do not enter secondary school record items. Enter only items applicable in higher education and professional circles. Enter the date, at least year, of each award. e.g. Phi Beta Kappa, 1988.

8. PUBLICATIONS: (For appointment, include all publications, for tenure: last five years only, for promotion to associate professor: since appointment to assistant professor; for promotion to professor since last promotion.) Give full bibliographic citations, including pagination. Do not include entries in which you were only cited in another's work. If you authored part of a work, indicate scope of your contribution, e.g., Chapter 2, Title, pp. 29-61.

9. MEMBERSHIP IN PROFESSIONAL SOCIETIES: Do not include social, political, ethnic, or charitable organizations which are connected with your personal life or affairs. Enter only professional organizations associated with your occupation or career. If you have only been a member, the entry should so indicate, e.g., American Historical Society, Member, 1989 - 1999. If you have served the organization in a special capacity, indicate the significance of your contribution, e.g., American Historical Association, Member, 1989 - 1999; served on Program Committee for annual convention,
REFERENCES: For appointment, candidates must submit the name and addresses of at least three professional references. Include name, organization or institution, and professional relationship to you. For reappointment with tenure or for promotion to Associate Professor or Professor, candidates must submit, in writing, the names of no less than three and no more than five professional references from outside BMCC. Include the professional affiliation of each reference and a brief explanation of how they know your work. The Vice President for Academic Affairs will review the references and you will be notified when they have been approved (or if any revision or clarification is required). Once the references have been approved it becomes your responsibility to request the letters from the references. All reference letters should be addressed to the Assistant to the Vice President for Faculty and Staff Relations. The Assistant to the Vice President for Faculty and Staff Relations will monitor receipt of the letters and notify you if the letters have not been received. It is, however, your responsibility to follow up and assure that the letters are submitted in a timely fashion.

CHAIRPERSON’S REPORT: To be completed by Departmental Chairperson.

STUDENT EVALUATIONS: To be completed by Departmental Chairperson. There should be a summary statement and a record of results for a period of at least three years, wherever possible.

RECORD AT THE COLLEGE: Enter date, and rank of initial appointment and previous promotions as appropriate. Information can be obtained from the Office of Human Resources (S710).

PERSONAL DATA: Please supply all requested information.
CURRICULUM VITAE

NAME: 

COLLEGE: BOROUGH OF MANHATTAN COMMUNITY COLLEGE

RECOMMENDATION FOR:

APPOINTMENT: 
PROMOTION: 
REAPPOINTMENT: 
REAPPOINTMENT WITH TENURE: 

OTHER: (Designation as Vice President, Dean, etc.)

TITLE: 

DEPARTMENT: 

EFFECTIVE DATE: 

SALARY RATE: 

HIGHER EDUCATION

A. Degrees

<table>
<thead>
<tr>
<th>Institution</th>
<th>Dates Attended</th>
<th>Degree and Major</th>
<th>Date Conferred</th>
</tr>
</thead>
</table>

B. Additional Higher Education and/or Education in Progress

<table>
<thead>
<tr>
<th>Institution</th>
<th>Date Attended</th>
<th>Courses, Etc.</th>
</tr>
</thead>
</table>
EXPERIENCE

A. Teaching

<table>
<thead>
<tr>
<th>Institutions</th>
<th>Dates</th>
<th>Rank</th>
<th>Department</th>
</tr>
</thead>
</table>

B. Other

<table>
<thead>
<tr>
<th>Institution</th>
<th>Date</th>
<th>Title</th>
</tr>
</thead>
</table>

ACADEMIC AND PROFESSIONAL HONORS

PUBLICATIONS
MEMBERSHIP IN PROFESSIONAL SOCIETIES

REFERENCES  (For tenure & promotion, 1st name title and affiliation only. For appointment, include address)
CHAIRPERSON'S REPORT (For reappointment, promotion, or reappointment with tenure)

STUDENT EVALUATION (For reappointment, promotion, or reappointment with tenure)
RECORD AT COLLEGE

Date

Rank

Salary Rate

$

PERSONAL DATA
Address:
Telephone No:
Military Status:
Social Security No:
Date of Birth:

______________________________
PRESIDENT

Date Submitted to CUNY Chancellor's Office
PERSONNEL DATA FORM

Please complete all items. (Type or print legibly.)

Name ____________________________

(Last) (First) (Middle) (Other last names used)

Job Title ____________________________

Area of Specialization ____________________________

Home Address ____________________________

(No.) (Street) (Apartment #)

(City) (State) (Zip Code)

Home Telephone ____________________________

(Area Code)

Date of Birth ____________________________ Social Security No. ____________________________

Citizen of the United States? Yes □ No □

If no, state type of Visa ____________________________ Date of Expiration ____________________________

Marital Status ____________________________ If married, full name of spouse ____________________________

Number of Children ____________________________ U.S. military status ____________________________

Handicapped: Yes □ No □ If yes, specify: ____________________________

Languages read easily ____________________________

Languages spoken easily ____________________________

Have you served or are you now serving either full-time or part-time in any college of the City University of New York? Yes □ No □

If yes, list the college, position, department, dates of employment and salary: ____________________________

________________________________________________________________________________________

________________________________________________________________________________________
EDUCATION (Please leave no gaps; account for all time since completion of high school study to the present; include colleges, universities, professional schools, etc.)

<table>
<thead>
<tr>
<th>Name and Address of School</th>
<th>Major</th>
<th>Minor</th>
<th>Degree or Professional License</th>
<th>Date Conferred</th>
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Additional higher education and/or education in progress

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<th>Courses, etc.</th>
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</table>

Title of Master's Thesis

Title of Doctoral Dissertation

Are you currently a candidate for the Ph.D. or Ed.D.? Yes □ No □

If yes, date course requirements fulfilled

Expected completion date of dissertation

Please list any professional license(s) you hold (not listed above); include type, year, and state.
**WORK EXPERIENCE** (List in reverse chronological order, beginning with your most recent or current position. If self-employed, so indicate.)

<table>
<thead>
<tr>
<th>Name and Address of Organization</th>
<th>Period (Dates)</th>
<th>Immediate Supervisor</th>
<th>Nature of Work &amp; Responsibility</th>
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<td>From:</td>
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<td>Title:</td>
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<td>To:</td>
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<td>To:</td>
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<td>Salary:</td>
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</tbody>
</table>

**PUBLICATIONS AND/OR CREATIVE WORK** (List all publications/books, pamphlets and periodical articles, reviews and notes. Do not include dissertations. Give full bibliographical reference: title, publisher, journal, volume, date, pages; submit reprints, if available.)

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Academic and professional honors (prizes, scholarships, fellowships, awards, etc.). Give particulars, including dates and institutions.


Membership in learned or professional societies (Indicate type of membership, office held, if any, the year of election, committee service, and other activities. Include dates.)


Additional information relevant to position.


How and/or by whom were you referred to BMCC?


REFERENCES (Persons who can attest to your scholarship and professional service.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution and Mailing Address</th>
<th>Title or Position</th>
<th>Telephone</th>
</tr>
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<tbody>
<tr>
<td>1</td>
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</tbody>
</table>

I certify that the statements made by me are true, complete and correct to the best of my knowledge and belief.

Date

Signature
The City University of New York
APPLICATION FOR EMPLOYMENT
SHORT FORM

COLLEGE

(Print)
Name in Full

Last

First

Middle

Home address

No. Street Apt. # City State Zip

Telephone Number ( ) S.S. No. / /

Home Business

Are you authorized to work in the U.S.? Yes No

Under the Immigration and Reform Control Act, CUNY is required to verify your employment eligibility and identity within three (3) days of your reporting to work.

EDUCATION: Please indicate highest equivalent grade of education completed (eg. GED= 12; BA= 16)

List schools attended, beginning with most recent (college, business, high school, vocation, trade etc.)

<table>
<thead>
<tr>
<th>School Name</th>
<th>Location</th>
<th>Date Entered</th>
<th>Date Left</th>
<th>Major Study</th>
<th>Total Credits Completed</th>
<th>Degree and Date Received</th>
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GED: Year Issued Certificate #: 

EMPLOYMENT HISTORY: Begin with present or last job and work back for the last 15 years, if job related. Attach an extra page, if necessary.

1. Firm Name

Dates Employed From / / To / /

Mo. Yr. Mo. Yr.

Address

Job Title

Final Base Salary/Indicate one:

( ) Annual $ 

( ) Weekly $ 

( ) Hourly $ 

Name and Title of

Immediate Supervisor

Reason for Leaving

Briefly describe duties

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</table>

2. Firm Name

Dates Employed From / / To / /

Mo. Yr. Mo. Yr.

Address

Job Title

Final Base Salary/Indicate one:

( ) Annual $ 

( ) Weekly $ 

( ) Hourly $ 

Name and Title of

Immediate Supervisor

Reason for Leaving

Briefly describe duties

<p>| | | | | | |</p>
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</table>

3. Firm Name

Dates Employed From / / To / /

Mo. Yr. Mo. Yr.

Address

Job Title

Final Base Salary/Indicate one:

( ) Annual $ 

( ) Weekly $ 

( ) Hourly $ 

Name and Title of

Immediate Supervisor

Reason for Leaving

Briefly describe duties

<p>| | | | | | |</p>
<table>
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</table>
1. May we contact the employers listed above prior to your being hired at CUNY? All employment (prior/current) will be verified after hire.
   Yes __ No __ If no, explain ____________________________

2. Have you previously been employed by CUNY? No __ Yes __ If yes, please give name of college, dates of employment, title(s) and reason for leaving.

3. Have you ever been discharged or asked to resign from any employment? No __ Yes __ If yes, please explain briefly. ____________________________

4. List any special skills that you possess that are either required for this job or which you believe will help you perform this job better (e.g. office machines, languages, word processor); be specific:

5. Are you physically, mentally and medically able, with or without reasonable accommodation, to perform fully the essential duties of this job as contained in the job description? Yes __ No __
   If No, you may still be eligible for appointment to the position. If appointed, be prepared to provide additional specific information.

6. Are you working or do you anticipate working at any other job? Yes __ No __
   If yes, give name of employer, days and time of work, nature of duties.

7. Are you currently a full-time student? Yes __ No __
   If yes, give name of school ____________________________ Credits earned this semester _________

8. Are you a retiree of either a New York City or State agency and currently collecting a pension? Yes __ No __
   If yes, are you willing to suspend pension payment if offered a position with CUNY? Yes __ No __

NOTICE (Please read carefully)

A material false statement or omission willfully or fraudulently made in this application (including attached papers and related interviews) will result in disqualification, even following appointment, and may result in criminal prosecution.

If the position for which this application is submitted requires, as a condition of employment, the applicant to successfully undergo a drug, alcohol, medical and/or psychological examination, failure to pass such examination or failure to report for such examination shall be grounds for non-appointment or for invalidating the appointment when an offer has been made. Any offer of employment is contingent on successful completion of The City University of New York's total employment screening process, including, when required, receipt of references which the University or College considers satisfactory.

Only the representations made by the President of the College or the College Appointing Officer – usually the College Personnel/Human Resources Director made in writing prior to appointment are official representations. No manager or representative of The City University of New York has the authority to make an offer of employment or to represent a condition of employment including those made in writing. If such an offer and/or condition is made by those other than the President or Appointing Officer it would be unenforceable because it would be a violation of the University Bylaws, Rules and Regulations, or Collective Bargaining Agreements governing the administrative policies of the University.

The City University reserves the right to revise without notice any personnel policy or practice at any time other than those set forth in the University Bylaws, applicable New York State Laws, Collectively Bargained Agreements, and the Rules of the CUNY Civil Service Commission.

Applicant's Certification and Agreement

I declare and affirm, under penalty of perjury, that I have read and understand the above notice, and that the statements I have made herein are true and correct to the best of my knowledge.

Your Signature: ____________________________ Date: ____________

FOR HUMAN RESOURCES MANAGEMENT SERVICES OFFICE USE

Date Received: ____________________________ Mailed: ____________________________ Drop In: ____________________________

Word Processing Score: ____________________________ Date: ____________________________ P.O. Staff Initials: ____________________________ (Attach summary sheet)

Interview Date: ____________________________ By: ____________________________ Position: ____________________________

Interview Date: ____________________________ By: ____________________________ Position: ____________________________

Interview Date: ____________________________ By: ____________________________ Position: ____________________________

EQUAL EMPLOYMENT OPPORTUNITY/AFFIRMATIVE ACTION, AMERICAN'S WITH DISABILITIES ACT, AND IMMIGRATION REFORM AND CONTROL ACT EMPLOYER

OFSR-601
R.1-4/01
Form W-4 (2004)

Purpose. Complete Form W-4 so that your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2004 expires February 16, 2005. See Pub. 505, Tax Withholding and Estimated Tax.

Basic Instructions. If you are exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the cost of keeping up a home for yourself and your dependents or other qualifying individuals. See line E below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 919, How Do I Adjust My Tax Withholding? for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two-earner/two-job. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8833 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2004. See Pub. 919, especially if your earnings exceed $125,000 (Single) or $175,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

Personal Allowances Worksheet (Keep for your records.)

A
Enter "1" for yourself if no one else can claim you as a dependent.

B
Enter "1" if:

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.

C
Enter "1" for your spouse. But, you may choose to enter "0-" if you are married and have either a working spouse or more than one job. (Entering "0-" may help you avoid having too little tax withheld.)

D
Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.

E
Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above).

F
Enter "1" if you have at least $1,500 of child or dependent care expenses for which you plan to claim a credit.

G
Child Tax Credit (including additional child tax credit):

- If your total income will be less than $52,000 ($77,000 if married), enter "2" for each eligible child.
- If your total income will be between $52,000 and $84,000 ($77,000 and $119,000 if married), enter "1" for each eligible child plus "1" additional if you have four or more eligible children.

H
Add lines A through G and enter total here. Note: This may be different from the number of exemptions you claim on your tax return.

For accuracy, complete all worksheets that apply.

Employee's Withholding Allowance Certificate

Your employer must send a copy of this form to the IRS if: (a) you claim more than 10 allowances or (b) you claim "Exempt" and your wages are normally more than $200 per week.

Type or print your first name and middle initial

Last name

Home address (number and street or rural route)

City or town, state, and ZIP code

Date

Employee's signature

For Privacy Act and Paperwork Reduction Act Notice, see page 2.
Deductions and Adjustments Worksheet

Note: Use this worksheet only if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2004 tax return.

1. Enter an estimate of your 2004 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2004, you may have to reduce your itemized deductions if your income is over $142,700 ($71,350 if married filing separately). See Worksheet 3 in Pub. 919 for details.)

2. Enter:
   \[ \begin{align*}
   \$9,700 & \text{ if married filing jointly or qualifying widow(er)} \\
   \$7,150 & \text{ if head of household} \\
   \$4,850 & \text{ if single} \\
   \$4,850 & \text{ if married filing separately}
   \end{align*} \]

3. Subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-".

4. Enter an estimate of your 2004 adjustments to income, including alimony, deductible IRA contributions, and student loan interest.

5. Add lines 3 and 4 and enter the total. (Include any amount for credits from Worksheet 7 in Pub. 919.)

6. Enter an estimate of your 2004 nonwage income (such as dividends or interest).

7. Subtract line 5 from line 4. Enter the result, but not less than "-0-".

8. Divide the amount on line 7 by $3,000 and enter the result here. Drop any fraction.

9. Enter the number from the Personal Allowances Worksheet, line H, page 1.

10. Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earner/Two-Job Worksheet, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1.

Two-Earner/Two-Job Worksheet

Note: Use this worksheet only if the instructions under line H on page 1 direct you here.

1. Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet).

2. Find the number in Table 1 below that applies to the LOWEST paying job and enter it here.

3. If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-".

4. On Form W-4, line 5, page 1. Do not use the rest of this worksheet.

Note: If line 1 is less than line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

4. Enter the number from line 2 of this worksheet.

5. Enter the number from line 1 of this worksheet.

6. Subtract line 5 from line 4.

7. Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here.

8. Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed.

9. Divide line 8 by the number of pay periods remaining in 2004. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2003. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck.

---

### Table 1: Two-Earner/Two-Job Worksheet

<table>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from HIGHEST paying job are—</td>
<td>AND, wages from LOWEST paying job are—</td>
<td>Enter on line 2 above</td>
</tr>
<tr>
<td>$0 - $40,000</td>
<td>$0 - $4,000</td>
<td>0</td>
</tr>
<tr>
<td>$40,001 - $80,000</td>
<td>4,001 - 8,000</td>
<td>1</td>
</tr>
<tr>
<td>$80,001 - $170,000</td>
<td>8,001 - 17,000</td>
<td>2</td>
</tr>
<tr>
<td>$170,001 and over</td>
<td>17,001 and over</td>
<td>3</td>
</tr>
<tr>
<td>$40,001 and over</td>
<td>$4,001 - 8,000</td>
<td>0</td>
</tr>
<tr>
<td>$8,001 - 15,000</td>
<td>8,001 - 15,000</td>
<td>1</td>
</tr>
<tr>
<td>$15,001 - 22,000</td>
<td>15,001 - 22,000</td>
<td>2</td>
</tr>
<tr>
<td>$22,001 - 25,000</td>
<td>22,001 - 25,000</td>
<td>3</td>
</tr>
<tr>
<td>$25,001 - 31,000</td>
<td>25,001 - 31,000</td>
<td>4</td>
</tr>
<tr>
<td>$31,001 - $38,000</td>
<td>31,001 - $38,000</td>
<td>5</td>
</tr>
<tr>
<td>$38,001 - $44,000</td>
<td>38,001 - $44,000</td>
<td>6</td>
</tr>
<tr>
<td>$44,001 - $50,000</td>
<td>44,001 - $50,000</td>
<td>7</td>
</tr>
<tr>
<td>$50,001 - $65,000</td>
<td>50,001 - $65,000</td>
<td>8</td>
</tr>
<tr>
<td>$65,001 - $70,000</td>
<td>65,001 - $70,000</td>
<td>9</td>
</tr>
<tr>
<td>$70,001 - $100,000</td>
<td>70,001 - $100,000</td>
<td>10</td>
</tr>
<tr>
<td>$100,001 and over</td>
<td>100,001 and over</td>
<td>11</td>
</tr>
</tbody>
</table>

---

### Table 2: Two-Earner/Two-Job Worksheet

<table>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from HIGHEST paying job are—</td>
<td>Enter on line 7 above</td>
</tr>
<tr>
<td>$0 - $30,000</td>
<td>$0 - $30,000</td>
</tr>
<tr>
<td>50,001 - 70,000</td>
<td>30,001 - 70,000</td>
</tr>
<tr>
<td>70,001 - 140,000</td>
<td>70,001 - 140,000</td>
</tr>
<tr>
<td>140,001 - $320,000</td>
<td>140,001 - $320,000</td>
</tr>
<tr>
<td>320,001 and over</td>
<td>320,001 and over</td>
</tr>
</tbody>
</table>

Privacy Act and Paperwork Reduction Act Notice: We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 6011 and 6602 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to Federal and state agencies to enforce Federal taxes criminal laws, or combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a validOMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The time needed to complete this form will vary depending on individual circumstances. The estimated average time is: Recordkeeping, 46 min.; Learning about the law or the form, 13 min.; Preparing the form, 59 min. If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Tax Products Coordinating Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001. Do not send Form W-4 to this address. Instead, give it to your employer.
New York State Department of Taxation and Finance
Employee’s Withholding Allowance Certificate
New York State • City of New York • City of Yonkers

Print or type
First name and middle initial
Last name

Your social security number

Permanent mailing address (number and street or rural route)
City, village, or post office
State
ZIP code

Apartment number

Complete the worksheet on page 3 before making any entries.

1. Total number of allowances you are claiming for New York State and the city of Yonkers, if applicable
   (from line 19)

2. Total number of allowances for city of New York (from line 30)

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3. New York State amount

4. City of New York amount

5. City of Yonkers amount

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee’s signature

Date

Penalty — A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employer’s name and address
(Employer: complete this section only if you must send a copy of this form to the New York State Tax Department.)

Employer identification number

Employers only: Please check the appropriate box(es) to indicate why you are sending a copy of this form to New York State:

☐ Employee is a new hire

☐ Employee claims more than 14 exemption allowances for New York State

Need help?

Internet access: www.nyss.gov
Access our Answer Center for answers to frequently-asked questions; check your refund status; check your estimated tax account; download forms, publications; get tax updates and other information.

Fax-on-demand forms: Forms are available 24 hours a day, 7 days a week. 1 800 748-3676

Telephone assistance is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday.
To order forms and publications: 1 800 462-8100
Refund status: (electronically filed) 1 800 353-0708
   (direct deposit) 1 800 321-3213
   (all others) 1 800 443-3200
Personal Income Tax Information Center: 1 800 225-5829
From areas outside the U.S. and outside Canada: (518) 485-5800
Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 171, 171-a, 287, 308, 429, 475, 505, 697, 1066, 1142, and 1413 of that Law, and may require disclosure of social security numbers pursuant to 42 USC 605(c)(2)(C)(I).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany, NY 12227; telephone 1 800 225-5829. From areas outside the United States and outside Canada, call (518) 485-5800.

Employee: detach this page and give it to your employer.
Changes for 2004

The additional withholding per week dollar amounts and the number of allowances in Chart I and Chart II on page 4 of the instructions for this form have been revised for tax year 2004. If you filed a 2003 Form IT-2104 (dated 8/03) based on the tax rate effective for tax year 2003, use Chart I or Chart II on page 4 of the 2003 Form IT-2104 to compute an additional dollar amount to claim on lines 3, 4, or 5 of Form IT-2104, you should complete a new 2004 Form IT-2104 and give it to your employer.

Who should file this form

The certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld. If you do not file Form IT-2104, your employer may use the same number of allowances you claimed on Federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers. Complete Form IT-2104 each year and file it with your employer if the number of allowances you claim is different than on federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or had an additional child).
- You itemize your deductions on your personal income tax return.
- Your claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn $100,000 or more during the tax year.
- The total income of you and your spouse has increased to $100,000 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.
- You have been advised by the Internal Revenue Service that you are entitled to fewer allowances than claimed on your original Form W-4, and the disallowed allowances have been claimed on your original Form IT-2104.

Employee: detach and give the first page to your employer; keep pages 3 and 4 for your records.

Exemption from withholding

You cannot use this Form IT-2104 to claim exemption from withholding. To claim exemption from income tax withholding, you must file Form IT-2104-E, Certificate of Exemption from Withholding, with your employer. You must file a new certificate each year that you qualify for exemption. This exemption from withholding is available only if you had no New York income tax liability in the prior year, you expect none in the current year, and you are over 65 years of age, under 18, or a full-time student under 25. If you are a dependent who is under 18 or a full-time student, you may owe tax if your income is more than $3,000.

Withholding allowances

You may not claim a withholding allowance for yourself or, if married, your spouse. Claim the number of withholding allowances you compute in Part I and Part III on page 3 of this form. If you want more tax withheld, you may claim fewer allowances. If you claim more than 14 allowances, your employer must send a copy of your Form IT-2104 to the New York State Tax Department. Your employer must verify your allowances. If you arrive at negative allowances, less than 100% on lines 1, 2, 19, or 30, and your employer cannot accommodate negative allowances, see Additional dollar amount(s) below.

Income from sources other than wages

If you have more than $1,000 of income from sources other than wages (such as interest, dividends, or alimony received), reduce the number of allowances claimed on line 1 and line 2 (if applicable) of the IT-2104 certificate by one for each $1,000 of nonwage income. If you arrive at negative allowances, see Withholding allowances above. You may also consider filing estimated tax, especially if you have significant amounts of non-wage income. Estimated tax requires that payments be made by the employee directly to the Tax Department on a quarterly basis. For more information, see the instructions for Form IT-2104, Estimated Income Tax Payment Voucher, or see Need help? on page 1.

Other credits (Worksheet line 12)

If you are eligible to take credits other than the credits listed, such as an investment tax credit, you may claim additional allowances as follows:

- If you expect your New York adjusted gross income to be less than $50,000, divide the amount of the credit by 60 and enter the result (rounded to the nearest whole number) on line 12.
- If you expect your New York adjusted gross income to be more than $50,000, divide the amount of the credit by 70 and enter the result (rounded to the nearest whole number) on line 12.

Example: You expect your New York adjusted gross income to exceed $50,000. In addition, you expect to receive a payment-in-kind of an investment tax credit from the S Corporation of which you are a shareholder. The investment tax credit will be $180. Divide the expected credit by 70: 160/70 = 2.2857. The additional withholding allowances would be 2. Enter "2" on line 12.

Married couples with only one spouse working

If your spouse does not work and has no income subject to state income tax, check the Married box on the front of the certificate. You may also wish to claim two additional withholding allowances on Part I, line 13.

Additional dollar amount(s)

You may ask your employer to withhold an additional dollar amount each pay period by completing lines 3, 4, and 5 on Form IT-2104. In most instances, if you compute a negative number of allowances using the worksheets on page 3 and your employer cannot accommodate a negative number, for each negative allowance claimed you should have an additional $2 of tax withheld per week for New York State withholding on line 3, and an additional $1 of tax withheld per week for New York City withholding on line 4. Yonkers residents should use 5% (0.05) of the New York State amount for additional withholding for the city of Yonkers on line 4.

Note: If you are requesting your employer to withhold an additional dollar amount on lines 3, 4, or 5 of this allowance certificate, the additional dollar amount as determined by these instructions or by using the charts on page 4 is accurate for a weekly payroll. Therefore, if you are paid other than weekly, you will need to adjust the dollar amount(s) that you compute. For example, if you are paid biweekly, you must double the dollar amount(s) computed using the worksheet on page 3.

Avoid underwithholding

Form IT-2104, together with your employer's withholding tables, is designed to ensure that the correct amount of tax is withheld from your pay. If you fail to pay enough tax withheld during the entire year, you may have a large tax liability when you file your tax return. Your tax department must assess interest and may impose penalties in certain situations in addition to the tax liability. Even if you do not owe a penalty, you may determine that you owe personal income tax, and we may assess interest and penalties on the amount of tax that you should have paid during the year.
Borough of Manhattan Community College  
Office of Human Resources  
Personnel Information form

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name (print)</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Title</th>
<th>Department</th>
<th>Date of Appointment</th>
</tr>
</thead>
</table>

( ) Female  ( ) Male  Date of Birth: ____________

<table>
<thead>
<tr>
<th>Ethnicity:</th>
<th>American Indian</th>
<th>Alaskan Native</th>
<th>Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black</td>
<td>Hispanic</td>
<td>Italian American</td>
</tr>
<tr>
<td></td>
<td>Pacific Islander</td>
<td>Puerto Rican</td>
<td>White</td>
</tr>
</tbody>
</table>

U.S. Citizen: ( ) Yes  ( ) No  If you are not a US Citizen, Of what country are you a citizen: ______________
Of what type of VISA are you holding: ______________ Expiration Date: ____________

Are you a Veteran? ( ) No  ( ) Yes  If you are a Veteran, please specify:
  ( ) Active Reserve  ( ) Disabled  ( ) Disabled Vietnam Era
  ( ) Inactive Reserve  ( ) Retired  ( ) Vietnam Era

Home Address: ____________________________ (Print)

Telephone Number: _________________________

Name of Emergency Contact: ______________ Relationship: ____________

Address: ________________________________

Telephone Number: ______________________ Business Number: ____________

Education: Degree  Major  Date Earned  Institution

________________________________________

To be completed by the Office of Human Resources

I-9 Date: __________ Work Authorization Expiration Date: __________

H.R. Staff Initial: ______ Date: ______

HR-2000
Unused Annual Leave Benefit – Designation of Beneficiary
Instructional Staff – Teaching and Non-Teaching

Name (Print) ___________________________ Social Security Number ___________________________

Title ___________________________

In accordance with Item No. 17 of the Board of Higher Education minutes of Proceeding
dated August 1, 1977, the payment of the accrued annual leave as provided for therein is
to be paid to the following beneficiaries or to my estate as indicated below in the
following manner:

1. PRIMARY BENEFICIARIES RELATIONSHIP % OF BENEFIT
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. CONTINGENT BENEFICIARIES RELATIONSHIP % OF BENEFIT
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. It is my understanding that by not designating a beneficiary, this benefit will be
paid to my estate.

All previous designated beneficiaries for cash payments of accrued annual leave are
hereby canceled and it is directed that payments be made upon by death as specified
above.

______________________________ ___________________________ ___________________________
Signature of Employee Date Signed at (City, State)

______________________________
Address of Employee

______________________________ ___________________________ ___________________________
Signature of Witness Date Signed at (City, State)

______________________________
Address of Witness
AMENDED CONSTITUTIONAL OATH UPON APPOINTMENT
(In compliance with Section 62 of the New York State Civil Service Law)

“I hereby pledge and declare that I will support the constitution of the United States, and the constitution of the state of New York, and that I will faithfully discharge the duties of the position of ________ according to the best of my ability.”

Name: __________________________

Signature: _______________________

Address: _________________________

Date: ___________________________
This form must be completed by all employees except those in the Managerial Pay Plan, original jurisdiction titles, and those employees specifically excluded from collective bargaining by decisions of the Office of Collective Bargaining.

NOTICE TO EMPLOYEE

Under an act passed by the New York State Legislature and by agreement between the City and municipal employee unions, bargaining unit employees who are not union members are subject to a deduction from their salary in an amount equal to the dues payable by a union member.

EMPLOYEE AFFIRMATION

I have been informed that I have the right to join or refrain from joining the union certified for my title. I understand that if I refrain from joining I will be subject to an Agency Shop Fee deduction which shall be an amount equivalent to the amount of dues payable by a union member.

Employee's Signature ____________________ Date ______________

TO BE FILLED OUT BY AGENCY

NOTICE TO UNION

Please be advised of the appointment or change in status of the employee as indicated below:

Employee Name: ____________________________ Social Security Number: ______________

Title: ____________________________ Check Digit __________

Job Sequence Number (JSN): ______________ Check one: Assigned [ ] Automatically [ ] Manually (List plan assigned)

Payroll No.: ______________ Title Code No.: ______________

Agency Address: ______________ Agency Clerk: ______________ Phone #: ______________

Name of Union ____________________________

To the Union: If the deduction plan was assigned incorrectly, submit correction to the Organizational Dues Unit, Office of Payroll Administration.

* FORWARD TO THE APPROPRIATE UNION
** MAINTAIN A COPY IN EMPLOYEE'S PERSONNEL FILE

DP-2328B (r. 6/93)
Dear Instructional Staff Member:

Congratulations on your appointment to The City University of New York.

As a new member of the instructional staff, you are entitled to a comprehensive pension benefit which allows you the option to choose from several retirement plans provided by the University. Specifically, within 30 days of your employment, you must choose to enroll in either the Optional Retirement Program offered through TIAA-CREF or the New York City Teachers' Retirement System. Failure to do so will automatically enroll you in the New York City Teachers' Retirement System. Once you are enrolled in either plan the decision is irrevocable.

If you are interested in enrolling in the Optional Retirement Program, the Enrollment Kit provided by TIAA-CREF will give you an overview of the retirement plan, explain what the TIAA-CREF retirement system is all about and demonstrate how it operates.

TIAA-CREF, a leading financial services organization and the largest private pension provider in the world, based on over $290 billion in assets, has been meeting the retirement needs of the education and research community for over 80 years. The company provides you with the opportunity to play an important role in your retirement planning by deciding how you want your funds allocated within the TIAA-CREF system.

If you need additional information before making your decision, or if you have questions about completing the TIAA-CREF enrollment form, please contact the Personnel Office at your college.

We look forward to working with you to achieve your retirement goals.

Sincerely,

[Signature]

Brenda Richardson Malone
Vice Chancellor
Your Enrollment Form

1. Provide some basic information about yourself

2. Choose an initial investment allocation

There are two ways you can choose an allocation. The transfer and withdrawal restrictions of the accounts differ and should be taken into consideration. You may change your allocation at any time.

Option A—Create Your Own Allocation
Choose the percentages you want to allocate to each TIAA-CREF fixed and variable annuity account. You can choose from any of the accounts available under your employer’s plan. If your allocation exceeds 100%, if it violates any plan limitations, or if we receive your contributions before we receive your enrollment form, your contributions will be allocated to the CREF Money Market Account. If your allocation is less than 100%, the omitted percentage will be allocated to the CREF Money Market Account. Upon receiving clarification from you, we will apply all future contributions according to your instructions. If you need help customizing your allocation:

Use our Asset Allocation Calculator, available at www.tiaa-cref.org
You’ll answer a series of questions and a portfolio will be suggested based on your responses. You’ll also find historical performance for the TIAA-CREF accounts and information on the variable account expenses in our prospectuses.

To have a customized allocation prepared, call a consultant at 800 842-2888
Consultants are available weekdays from 8 am to 11 pm, and weekends from 9 am to 6 pm, ET.

Option B—Select One of Our Sample Portfolios
Our sample portfolios are examples that can be created using the TIAA-CREF fixed and variable annuity accounts. These portfolios are not recommendations and do not take into consideration your personal goals or preferences. After you take into account information you consider important in making an investment choice, the ultimate allocation decision is up to you.

3. Designate your beneficiary(ies)

Your primary beneficiary(ies) will be paid any survivor benefit existing under the contract at your death. If there are no surviving primary beneficiaries, your contingent beneficiary(ies) will receive these benefits. If you are married, provisions under your employer’s plan may require you to name your spouse as primary beneficiary for at least a portion of the benefit. You can call a consultant at 800 842-2888 for further information about choosing your beneficiaries.

4. Indicate any existing contracts

We are complying with a regulatory requirement in asking that you provide information on existing contracts. You need to answer “Yes” only if these TIAA-CREF contracts will completely replace existing contracts under the same retirement plan at your employer.

5. Remember to sign your form

Next steps...

Return your enrollment form to your employer’s benefits office. You may need to complete a salary reduction agreement with your employer.

Complete the Transfer/Rollover Authorization to TIAA-CREF form. If you have funds with another financial carrier that you would like to consolidate with TIAA-CREF, just return the Transfer/Rollover Authorization form to us. Before making a transfer, be sure to consider any surrender charges the other company may deduct.
### THE TIAA-CREF FIXED AND VARIABLE ANNUITY ACCOUNTS

You can choose among the TIAA Traditional fixed annuity and the TIAA-CREF variable annuity accounts. For more detailed information, see your enrollment kit brochure and the prospectuses. Some of the accounts may not be available under your employer's plan. If you have questions about account availability, call our Enrollment Hotline at 800 842-2888.

#### GUARANTEED

**TIAA Traditional**—guarantees your principal and a specified interest rate (backed by TIAA's claims-paying ability), plus offers additional growth opportunity through dividends, which are established on a year-by-year basis but are not guaranteed for future years. Because TIAA invests in long-term, relatively illiquid investments in an effort to obtain increased yields, withdrawals and transfers from TIAA Traditional must be spread over a ten-year period.

**EQUITIES**

**CREF Stock**—a broadly diversified portfolio investing the majority of its assets in U.S. stocks. Two-thirds of the portfolio uses enhanced indexing to reflect the overall U.S. stock market. The remainder is actively managed, divided fairly equally between U.S. and foreign stocks. (Foreign markets are subject to additional risks from changing currency values, interest rates, government regulations, and political and economic conditions.)

**CREF Global Equities**—invests between 40% and 75% of its assets in foreign stocks with the remainder in U.S. securities. This portfolio combines individual stock selection with enhanced indexing. (Foreign markets are subject to additional risks from changing currency values, interest rates, government regulations, and political and economic conditions.)

**CREF Growth**—invests in stocks that may offer superior growth potential based on economic and market conditions. A second portfolio component uses enhanced indexing to reflect a broadly based index of U.S. growth stocks.

**CREF Equity Index**—encompasses almost the entire range of U.S. stocks. This account uses enhanced indexing to reflect the returns of the Russell 3000.*

#### REAL ESTATE

**TIAA Real Estate**—invests the majority of its assets in income-producing commercial properties with the remainder in liquid assets such as money market instruments and other securities. Real estate has specific risks, including fluctuations in property value, higher expenses or lower income than expected, and environmental problems and liability. Transfers from the TIAA Real Estate Account are limited to once per calendar quarter.

#### FIXED INCOME

**CREF Money Market**—invests in securities and other instruments that will mature in the near future and therefore tend to reflect changes in current interest rates. This account is neither insured nor guaranteed by the Federal Deposit Insurance Corporation or any other government agency.

**CREF Bond Market**—invests primarily in high- and medium-quality corporate and government bonds of varying maturities. The bonds are often actively bought and sold rather than held to maturity.

**CREF Inflation-Linked Bond**—invests primarily in bonds whose principal or interest is adjusted to track the inflation rate.

#### EQUITIES & FIXED INCOME

**CREF Social Choice**—a portfolio of stocks, bonds, and money market instruments that screens out investments not meeting certain social criteria.

*Note: The Russell 3000, compiled by the Frank Russell Company, is an unmanaged index of the stocks of the 3,000 largest U.S. companies traded on the New York Stock Exchange, other U.S. exchanges and over the counter (i.e., stocks such as those listed on NASDAQ). Each stock in the index is weighted by its relative market value. The CREF Equity Index Account is not promoted or sponsored by or affiliated with the Frank Russell Company, which is not responsible for any representations about the account. You cannot purchase shares in the index. The Russell 3000 is a registered trademark of the Frank Russell Company.

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### THE SAMPLE PORTFOLIOS YOU MAY WANT TO CHOOSE FROM

**CONSERVATIVE**

60% TIAA Traditional, 30% CREF Stock, 10% TIAA Real Estate

This portfolio's high percentage in TIAA Traditional makes it appropriate for someone who is primarily concerned with safety and stability. The equity portion offers investment in CREF Stock, which is broadly diversified within itself. The allocation to TIAA Real Estate provides additional diversification.

**MODERATELY CONSERVATIVE**

45% TIAA Traditional, 45% CREF Stock, 10% TIAA Real Estate

This portfolio seeks a balance between safety and growth potential. It is diversified, including stock and real estate accounts, as well as the guarantees of TIAA Traditional.

A note about risk: Remember, all the sample portfolios offer investment within equity accounts. The more aggressive the sample portfolio, the greater the risk of loss.

**MODERATELY AGGRESSIVE**

25% TIAA Traditional, 30% CREF Stock, 20% CREF Global Equities, 15% CREF Growth, 10% TIAA Real Estate

This portfolio seeks growth opportunity while maintaining a percentage in TIAA Traditional to help enhance overall safety. The equity accounts offer growth opportunity through broad diversification, indexed and active investment approaches, and participation in both domestic and global investments. TIAA Real Estate adds diversification.

**AGGRESSIVE**

10% TIAA Traditional, 35% CREF Stock, 20% CREF Global Equities, 25% CREF Growth, 10% TIAA Real Estate

This portfolio provides a risk-tolerant investor with a way to take advantage of the long-term growth opportunities of stocks, including a healthy allocation to the CREF Growth Account. The guarantees of TIAA Traditional provide some balance to the risks of stock investing, and TIAA Real Estate enhances diversification.

Remember, if you'd like to select an allocation other than these sample portfolios, we can help you create your own allocation by using our Asset Allocation Calculator at www.tiaa-cref.org or by calling 800 842-2888.
Your Personal Information

Last Name | First | Middle | □ Mr. | □ Mrs. | □ Ms. | □ Dr. | □ Other
Mailing Address | Street | Apt. No. | City | State | Zip Code

Daytime Telephone Number | Extension | E-mail Address
( )

Sex | Date of Birth | Social Security Number | Spouse’s Name
□ M | □ F | Mo. | Day | Yr.

Employer | Campus / Branch | Job Title / Position

Your Premium Allocation — Choose Option A OR Option B

Option A — Create your own allocation.

<table>
<thead>
<tr>
<th>Guaranteed</th>
<th>Equities</th>
<th>Fixed Income</th>
<th>Real Estate</th>
<th>CREF Inflation-Linked Bond</th>
<th>Equities &amp; Fixed</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIAA Traditional</td>
<td>CREF Stock</td>
<td>CREF Global Equities</td>
<td>CREF Growth</td>
<td>CREF Equity Index</td>
<td>TIAA</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

OR

Option B — Select an allocation from our sample portfolios. These are examples and not recommendations. Your allocation should reflect your personal goals and investment preferences.

□ Conservative | □ Moderately Conservative | □ Moderately Aggressive | □ Aggressive

3. Your Beneficiary(ies)

Name(s) of Primary Beneficiary(ies) | Relationship to You | Date of Birth | Social Security Number (If unavailable, provide later)

Name(s) of Contingent Beneficiary(ies) | Relationship to You | Date of Birth | Social Security Number (If unavailable, provide later)

OVER PLEASE
New York City
Office of Labor Relations
Health Benefits Program
www.nyc.gov/html/olr

Fall 2003 Transfer Period

The 2003 Health Benefits Program Transfer Period begins October 15, 2003 and ends on November 14, 2003. Health plan changes requested during the Transfer Period will be effective the first day of the first full payroll period in January 2004.

During the Transfer Period, employees may transfer into any health plan listed below for which they may be eligible, or add or drop Optional Rider coverage or add or drop dependents in their present plan. Some plans are restricted to employees of a specific agency, members of a particular union, or residents of specific zip code areas. Please visit our website at www.nyc.gov/html/olr for up-to-date information. You may also call the health plans directly for additional information or visit their websites listed below.

To transfer, add or drop an Optional Rider, or add or drop dependents, you must complete a Health Benefits Application available from your agency health benefits representative or you can download it from www.nyc.gov/html/olr.

To elect the Waiver Buy-Out Program or change health premium contribution tax status, you must fill out both a Health Benefits Application and a Medical Spending Conversion Enrollment Change Form. All forms are available from your agency payroll or personnel office or you can download them from www.nyc.gov/html/olr.

All forms must be completed and returned to your payroll or personnel office no later than November 14, 2003.

Health Maintenance Organizations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Phone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna HMO</td>
<td>(800) 445-8742</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>CIGNA HealthCare</td>
<td>(800) 832-3211</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
<tr>
<td>Empire HMO (NY)</td>
<td>(800) 767-8672</td>
<td><a href="http://www.empireblue.com">www.empireblue.com</a></td>
</tr>
<tr>
<td>Empire HMO (NJ)</td>
<td>(888) 676-6986</td>
<td><a href="http://www.empireblue.com">www.empireblue.com</a></td>
</tr>
<tr>
<td>GHI HMO</td>
<td>(877) 244-4466</td>
<td><a href="http://www.ghihmo.com">www.ghihmo.com</a></td>
</tr>
<tr>
<td>Health Net</td>
<td>(800) 441-5741</td>
<td><a href="http://www.health.com">www.health.com</a></td>
</tr>
<tr>
<td>HIP PRIME HMO</td>
<td>(800) 447-6929</td>
<td><a href="http://www.hipusa.com">www.hipusa.com</a></td>
</tr>
<tr>
<td>MetroPlus (HHC employees only)</td>
<td>(800) 303-9626</td>
<td><a href="http://www.nyc.gov/html/hhc">www.nyc.gov/html/hhc</a></td>
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<tr>
<td>Vytra Health Plans</td>
<td>(800) 448-2527</td>
<td><a href="http://www.vytra.com">www.vytra.com</a></td>
</tr>
</tbody>
</table>

Point of Service, Exclusive Provider Organization, and Participating Provider Organizations/Indemnity Plans

<table>
<thead>
<tr>
<th>Organization</th>
<th>Phone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna QPOS</td>
<td>(800) 445-8742</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>DC37 Med-Team (DC37 members only)</td>
<td>(212) 501-4444</td>
<td><a href="http://www.ghi.com">www.ghi.com</a></td>
</tr>
<tr>
<td>Empire EPO</td>
<td>(800) 767-8672</td>
<td><a href="http://www.empireblue.com">www.empireblue.com</a></td>
</tr>
<tr>
<td>GHI-CBP/Empire BlueCross Blue Shield Group Health Incorporated:</td>
<td>(212) 501-4444</td>
<td><a href="http://www.ghi.com">www.ghi.com</a></td>
</tr>
<tr>
<td>Empire BlueCross BlueShield:</td>
<td>(800) 433-9592</td>
<td><a href="http://www.empireblue.com">www.empireblue.com</a></td>
</tr>
</tbody>
</table>
| HIP Prime POS                      | (800) 447-6929 | www.hipusa.com
### Basic plan and Optional Rider Costs

These rates are in effect as of the first full payroll period in July 2003
(All rates are subject to change)

<table>
<thead>
<tr>
<th>Plan Provider</th>
<th>Plan Type</th>
<th>Weekly</th>
<th>Bi-Weekly</th>
<th>Semi-Monthly</th>
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<td>Individual</td>
<td>Family</td>
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<td>Family</td>
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<td>Prescription Drugs</td>
<td>8.01</td>
<td>21.90</td>
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<tr>
<td></td>
<td>Total</td>
<td><strong>22.01</strong></td>
<td><strong>56.44</strong></td>
<td><strong>44.03</strong></td>
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<td>Optional Rider</td>
<td>Prescription Drugs</td>
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<td>40.05</td>
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<td>37.02</td>
<td>19.66</td>
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<td>Optional Rider</td>
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<td>12.82</td>
<td>31.55</td>
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<td>Total</td>
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<td><strong>68.57</strong></td>
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<td>Total</td>
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<td>Optional Rider</td>
<td>Prescription Drugs</td>
<td>11.33</td>
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<td>Total</td>
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<td><strong>117.88</strong></td>
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<td>Optional Rider</td>
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<td>27.77</td>
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<td>Total</td>
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<td>Optional Rider</td>
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<td>Optional Rider</td>
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<td>Outpatient Mental Health &amp; Inpatient Chemical Dependency Treatment</td>
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<td>Enhanced NYC Non-Par Provider Reimbursement Schedule</td>
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<td><strong>46.22</strong></td>
<td><strong>32.19</strong></td>
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<td>HealthNet</td>
<td>Basic Plan</td>
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<td>46.42</td>
<td>30.18</td>
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<td>Optional Rider</td>
<td>Prescription Drugs</td>
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<td>52.64</td>
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<td></td>
<td>Total</td>
<td><strong>35.45</strong></td>
<td><strong>99.06</strong></td>
<td><strong>70.90</strong></td>
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<td>HIP Prime HMO</td>
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<td>0.00</td>
<td>0.00</td>
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<tr>
<td></td>
<td>Optional Rider</td>
<td>Prescription Drugs</td>
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<td>35.73</td>
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<td>Appliances &amp; Private Duty Nursing</td>
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<td>1.33</td>
<td>1.08</td>
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<td>Total</td>
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<td><strong>37.06</strong></td>
<td><strong>30.24</strong></td>
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<td>Basic Plan</td>
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<td>56.07</td>
<td>45.75</td>
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<tr>
<td></td>
<td>Optional Rider</td>
<td>Prescription Drugs</td>
<td>17.75</td>
<td>43.49</td>
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<td>Total</td>
<td><strong>40.63</strong></td>
<td><strong>99.56</strong></td>
<td><strong>81.26</strong></td>
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<td>Metroplus (HHC Employees Only)</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>Optional Rider</td>
<td>Prescription Drugs</td>
<td>12.21</td>
<td>29.20</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td><strong>12.21</strong></td>
<td><strong>29.20</strong></td>
<td><strong>24.42</strong></td>
</tr>
<tr>
<td>Vytra</td>
<td>Basic Plan</td>
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<td>16.98</td>
<td>5.34</td>
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<tr>
<td></td>
<td>Optional Rider</td>
<td>Prescription Drugs</td>
<td>8.48</td>
<td>22.31</td>
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<td></td>
<td>Total</td>
<td><strong>11.15</strong></td>
<td><strong>39.29</strong></td>
<td><strong>22.30</strong></td>
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</tbody>
</table>

Fall 2003 Transfer Period
<table>
<thead>
<tr>
<th>Service</th>
<th>Aetna US Healthcare HMO</th>
<th>CIGNA HealthCare</th>
<th>Empire HMO</th>
<th>GHI HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care/Office Visits</strong></td>
<td>$5 copay</td>
<td>$10 copay</td>
<td>$15 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>Specialist Care</strong></td>
<td>$5 copay</td>
<td>$10 copay</td>
<td>$15 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic Tests (X-rays, labs, etc.)</strong></td>
<td>$5 copay</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Lab covered in full X-rays – $15 copay</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care</strong></td>
<td>Covered in full</td>
<td>$150 copay per admission</td>
<td>$250 copay/individual coverage $625 copay/family coverage</td>
<td>Covered in full</td>
</tr>
<tr>
<td><strong>Maternity Care (Mother and Newborn)</strong></td>
<td>$5 copay initial visit</td>
<td>$10 copay initial visit</td>
<td>Covered in full along with Empire BabyCare</td>
<td>$15 copay for OB/GYN visits Hospital covered in full</td>
</tr>
<tr>
<td><strong>Emergency Room Care</strong></td>
<td>$35 copay, waived if admitted</td>
<td>$50 copay, waived if admitted</td>
<td>$35 copay, waived if admitted</td>
<td>$35 copay, waived if admitted</td>
</tr>
<tr>
<td><strong>Mental Health Inpatient Care</strong></td>
<td>Covered in full for 35 days per 365-day period.</td>
<td>$150 copay per admission; covered up to 30 days per contract year</td>
<td>Covered in full 30 days Subject to copay ($250 individual/$625 family)</td>
<td>Covered in full 30 days per calendar year</td>
</tr>
<tr>
<td><strong>Mental Health Outpatient Care</strong></td>
<td>$25 copay per visit for 20 visits per 365 period.</td>
<td>$20 copay per session for 20 sessions per contract year</td>
<td>$25 copay per visit – 20 visits</td>
<td>20 visits per calendar year $15 copay visits 1-5 $25 copay visits 6-20</td>
</tr>
<tr>
<td><strong>Substance Abuse/Chemical Dependency Inpatient Care</strong></td>
<td>Detox covered in full for acute phase of treatment Rehab not covered</td>
<td>Detox $150 copay per admission; covered up to 30 days (combined annual max. for drug and/or alcohol treatment) Rehab not covered</td>
<td>Rehab covered in full 30 days annually 7 days detox annually and subject to copay ($250 indiv./$625 family)</td>
<td>Detox covered in full 7 days combined per calendar year for drug and/or alcohol treatment. Rehab covered in full up to 30 days combined for drug and/or alcohol treatment</td>
</tr>
<tr>
<td><strong>Substance Abuse/Chemical Dependency Outpatient Care</strong></td>
<td>$5 copay per visit. 60 visit combined annual maximum for drug and/or alcohol treatment</td>
<td>$10 copay per session for up to 60 sessions</td>
<td>Covered in full 60 visits (includes 20 visits family counseling)</td>
<td>$15 copay per visit – 60 visits combined per calendar year for drug and/or alcohol treatment</td>
</tr>
<tr>
<td><strong>Prescription Drug Coverage</strong></td>
<td>Available through optional rider</td>
<td>Available through optional rider</td>
<td>Available through optional rider</td>
<td>Available through optional rider</td>
</tr>
</tbody>
</table>

**NOTE:** Coverage levels indicated apply only if care is provided or authorized by a participating physician.

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.
## COMPARISON OF HEALTH MAINTENANCE ORGANIZATION BENEFITS
(Services from Participating Providers Only)

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP Prime HMO</th>
<th>MetroPlus Health Plan</th>
<th>PHS Health Plans</th>
<th>Vytra Health Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care/Office Visits</strong></td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>$5 copay</td>
<td>$5 copay</td>
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<tr>
<td><strong>Specialist Care</strong></td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>$5 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic Tests</strong></td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>(X-rays, labs, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care</strong></td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td><strong>Maternity Care (Mother and Newborn)</strong></td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td><strong>Emergency Room Care</strong></td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>$50 copay, waived if admitted</td>
<td>$25 copay, waived if admitted</td>
</tr>
<tr>
<td><strong>Mental Health Inpatient Care</strong></td>
<td>Covered in full 30 days per calendar year</td>
<td>Covered in full 30 days (combined annual maximum for drug, alcohol and/or mental health)</td>
<td>Covered in full 30 days per calendar year when approved in advance</td>
<td>Covered in full 30 days per calendar year</td>
</tr>
<tr>
<td><strong>Mental Health Outpatient Care</strong></td>
<td>$5 copay per visit - 20 visits per calendar year</td>
<td>$25 copay per visit - 20 visits</td>
<td>$20 copay per visit – 20 visits per calendar year. (After 6th visit must be approved in advance by PHS)</td>
<td>Covered for 20 visits per calendar year: $5 copay visits 1-3, $25 copay visits 4-20</td>
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<tr>
<td><strong>Substance Abuse/Chemical Dependency</strong></td>
<td>Detox covered in full – 30 days. Rehab not covered</td>
<td>Detox covered in full Rehab covered in full 30 days (combined annual maximum for drug, alcohol and/or mental health)</td>
<td>Detox covered in full Rehab covered in full up to 30 days per calendar year when approved in advance</td>
<td>Detox covered in full for 3 periods per calendar year for drugs and/or alcohol Rehab not covered</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse/Chemical Dependency</strong></td>
<td>Covered in full 60 visits per calendar year</td>
<td>Covered in full 60 visits per calendar year (combined annual maximum for drug, alcohol and/or mental health)</td>
<td>$5 copay per visit – 60 visits per calendar year when approved in advance</td>
<td>$5 copay per visit, 60 visit combined annual maximum for drug and/or alcohol</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>Available through optional rider</td>
<td>Available through optional rider</td>
<td>Available through optional rider</td>
<td>Available through optional rider</td>
</tr>
</tbody>
</table>

**NOTE:** Coverage levels indicated apply only if care is provided or authorized by a participating physician.

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.
### COMPARISON OF EXCLUSIVE PROVIDER ORGANIZATION (EPO), POINT-OF-SERVICE (POS) AND PREFERRED PROVIDER ORGANIZATION (PPO) / INDEMNITY PLAN BENEFITS (Services Both In- and Out-of-Network)

<table>
<thead>
<tr>
<th></th>
<th>Aetna U.S. Healthcare Quality Point of Service</th>
<th>DC 37 Med-Team/Choice</th>
<th>Empire EPO</th>
<th>GHI-CBP / Empire Blue Cross Blue Shield</th>
<th>HIP Prime POS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$250/Individual $500/Family</td>
<td>$300/Individual $750/Family</td>
<td>None</td>
<td>$175/Individual $500/Family $500/Family</td>
<td>$250/Individual $500/Family</td>
</tr>
<tr>
<td><strong>Maximum Out-of-Pocket</strong></td>
<td>$2,500/Individual $7,500/Family</td>
<td>$3,000/Individual $7,500/Family</td>
<td>None</td>
<td>$1,500 per person</td>
<td>$2,000/Individual $4,000/Family</td>
</tr>
<tr>
<td><strong>Physician’s Office Visits</strong></td>
<td><strong>In-Network</strong> $5 copay</td>
<td><strong>In-Network</strong> $10 copay</td>
<td><strong>In-Network</strong> $15 copay</td>
<td><strong>In-Network</strong> $10 copay</td>
<td><strong>In-Network</strong> Covered in full</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong> Covered 80% after deductible</td>
<td><strong>Out-of-Network</strong> Covered 70% of allowable amount after deductible</td>
<td><strong>Out-of-Network</strong> Covered in network only</td>
<td><strong>Out-of-Network</strong> Covered 80% after deductible</td>
<td><strong>Out-of-Network</strong> Covered in full</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic Tests (X-rays, labs, etc.)</strong></td>
<td><strong>In-Network</strong> $5 copay may apply</td>
<td><strong>In-Network</strong> Covered in full</td>
<td><strong>In-Network</strong> $10 copay</td>
<td><strong>In-Network</strong> Covered in full</td>
<td><strong>Out-of-Network</strong> Covered 80% after deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong> 80% coinsurance after deductible</td>
<td><strong>Out-of-Network</strong> Covered 70% of allowable amount after deductible</td>
<td><strong>Out-of-Network</strong> Services rendered in network only</td>
<td><strong>Out-of-Network</strong> Services rendered in network only</td>
<td><strong>Out-of-Network</strong> Covered 80% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care</strong></td>
<td><strong>In-Network</strong> Covered in full</td>
<td><strong>In-Network</strong> Copay: $100 Indiv.; $250 Family</td>
<td><strong>In-Network</strong> Covered in full with prior approval and subject to copay $250 ind./$625 fam.</td>
<td><strong>In-Network</strong> Covered for 365 days in full after $200 inpatient deductible ($500 annual max. per person)</td>
<td><strong>Out-of-Network</strong> Covered 80% after deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong> Covered 80% after deductible</td>
<td><strong>Out-of-Network</strong> Covered 70% of allowable amount after deductible</td>
<td><strong>Out-of-Network</strong> Services rendered in network only</td>
<td><strong>Out-of-Network</strong> Subject to penalty if not precertified by NYC Healthiine</td>
<td><strong>Out-of-Network</strong> Covered 80% after deductible</td>
</tr>
<tr>
<td><strong>Maternity Care (Mother and Newborn)</strong></td>
<td><strong>In-Network</strong> $5 copay initial visit</td>
<td><strong>In-Network</strong> Covered in full</td>
<td><strong>In-Network</strong> $10 copay first prenatal visit only</td>
<td><strong>Out-of-Network</strong> Physician: Per schedule of allowances after deductible</td>
<td><strong>Out-of-Network</strong> Covered 80% after deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong> 80% coinsurance after deductible</td>
<td><strong>Out-of-Network</strong> Covered 70% of allowable amount after deductible</td>
<td><strong>Out-of-Network</strong> Services rendered in network only</td>
<td><strong>Out-of-Network</strong> Hospital: Mother, $200 deductible</td>
<td><strong>Out-of-Network</strong> Covered 80% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room Care</strong></td>
<td>$35 copay, waived if admitted</td>
<td>$50 copay, waived if admitted within 24 hours</td>
<td>$35 copay, waived if admitted</td>
<td>$25 copay, waived if admitted</td>
<td><strong>Out-of-Network</strong> Covered in full; $50 charge if HIP is not contacted</td>
</tr>
<tr>
<td><strong>Prescription Drug Coverage</strong></td>
<td>Available through optional rider</td>
<td>Available through DC 37 Health &amp; Security Plan</td>
<td>Available through optional rider</td>
<td>Available through optional rider</td>
<td>Available through optional rider</td>
</tr>
</tbody>
</table>

**NOTE:** In-network coverage applies only if care is provided or authorized by a participating physician. Some plans require referral, authorization or notification before the use of non-participating providers is covered.

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.
<table>
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<th>HIP Prime POS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Inpatient Care</strong></td>
<td><strong>In-Network</strong> Covered in full 35 days per 365-day period</td>
<td><strong>In-Network</strong> Covered in full 30 days per calendar year. (Inc. substance abuse) Subject to deductible of $100 indiv./$250 family</td>
<td><strong>In-Network</strong> Covered in full 30 days per year and subject to copay $250 indiv./$625 family</td>
<td><strong>In-Network</strong> Covered in full 30 days per year</td>
<td><strong>In-Network</strong> Covered in full up to 30 days per year</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong> 80% after deductible. 35 days per 365-day period</td>
<td><strong>Out-of-Network</strong> Not covered</td>
<td><strong>Out-of-Network</strong> Not covered</td>
<td><strong>Out-of-Network</strong> 50% of Network allowance; 30 days per year</td>
<td><strong>Out-of-Network</strong> 30 days per year at 50% of Network allowance</td>
</tr>
<tr>
<td><strong>Mental Health Outpatient Care</strong></td>
<td><strong>In-Network</strong> $25 copay per visit for 20 visits per 365-day period</td>
<td><strong>In-Network</strong> $25 copay – 20 visits per calendar year</td>
<td><strong>In-Network</strong> $10 copay for 30 visits per year; 5 assessment visits covered in full See Optional Rider for additional benefits</td>
<td><strong>In-Network</strong> $5 copay per visit – 20 visits per calendar year</td>
<td><strong>Out-of-Network</strong> Covered 50% up to 20 visits (combined with in-network visits)</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong> 50% after deductible, 20 visits per 365-day period</td>
<td><strong>Out-of-Network</strong> Not covered</td>
<td><strong>Out-of-Network</strong> Not covered</td>
<td><strong>Out-of-Network</strong> Available through optional rider only</td>
<td><strong>Out-of-Network</strong> Covered 50% up to 20 visits (combined with in-network visits)</td>
</tr>
<tr>
<td><strong>Substance Abuse/Chemical Dependency Inpatient Care</strong></td>
<td><strong>In-Network</strong> Detox covered in full for acute phase of treatment; Rehab covered in full 30 days per year combined annual maximum for drug and/or alcohol treatment</td>
<td><strong>In-Network</strong> Covered in full 30 days per calendar year (includes mental health) 7 days detox per year. Subject to copay $100 individual/$250 family</td>
<td><strong>In-Network</strong> Detox covered in full 30 days annually; Detox covered in full 7 days annually and subject to copay ($250 indiv./$625 family)</td>
<td><strong>In-Network</strong> Detox, Rehab covered in full up to 30 days per year, 60 days per lifetime See Optional Rider for additional benefits</td>
<td><strong>Out-of-Network</strong> Detox covered at average network allowance; Rehab not covered See Optional Rider for additional benefits</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong> Detox covered at 80% after deductible 30 days per year Rehab covered at 80% after deductible 30 days per year</td>
<td><strong>Out-of-Network</strong> Not covered</td>
<td><strong>Out-of-Network</strong> Not covered</td>
<td><strong>Out-of-Network</strong> Detox covered at average network allowance; Rehab not covered See Optional Rider for additional benefits</td>
<td><strong>Out-of-Network</strong> Detox covered at average network allowance; Rehab not covered See Optional Rider for additional benefits</td>
</tr>
<tr>
<td><strong>Substance Abuse/Chemical Dependency Outpatient Care</strong></td>
<td><strong>In-Network</strong> $5 copay per visit 60-visit combined annual maximum drug and/or alcohol treatment</td>
<td><strong>In-Network</strong> Covered in full 60 visits, which may include 20 visits family counseling</td>
<td><strong>In-Network</strong> Covered in full 60 visits (includes 20 visits family counseling)</td>
<td><strong>In-Network</strong> Covered in full 60 visits combined annual maximum for drug/alcohol treatment</td>
<td><strong>In-Network</strong> Covered in full 60 visits combined annual maximum for drug/alcohol treatment</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong> Covered at 80% after deductible for 60-visit combined annual maximum for alcohol and/or drug treatment</td>
<td><strong>Out-of-Network</strong> Not covered</td>
<td><strong>Out-of-Network</strong> Not covered</td>
<td><strong>Out-of-Network</strong> 75% of Network allowance; 60 visits annually</td>
<td><strong>Out-of-Network</strong> Covered 80% up to 60 visits (combined with In-Network visits)</td>
</tr>
</tbody>
</table>

**NOTE:** In-network coverage applies only if care is provided or authorized by a participating physician. Some plans require referral, authorization or notification before the use of non-participating providers is covered.

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.
Instructions for Completing a Health Benefits Application
(For Employees)

(Please print all information clearly using a black or blue ballpoint pen)

Check the EMPLOYEE box at the top of the form.

Sections A, B & C: Check off the reason for submission of this form.

Employees may only transfer plans during a transfer period or upon a change of residence outside/inside of the service area of the health plan. Documentation verifying spouse or domestic partner and dependent children must be submitted for all new enrollments and addition of dependents. Obtain a domestic partner instruction sheet from your personnel office or the Office of Labor Relations if you wish to include a domestic partner on your medical coverage.

If you are adding or dropping a dependent or changing plans, this form should be submitted within 31 days of the qualifying event.

Section D: If you are enrolled in a health plan other than your City coverage, you must indicate so and include the name and policy number of the plan.

Section E: If you are married or have a domestic partner, this section must be completed whether or not you are covering your spouse/domestic partner. If your spouse/domestic partner is enrolled in a health plan other than your City coverage, you must indicate so including the name and policy number of the other plan.

Section F: List ALL dependents to be covered. You must indicate yes/no if a dependent is a full-time student or if a dependent is permanently disabled.

Section G: Write the complete name of the health plan you are selecting or your current plan (see back of this sheet) if you are adding or dropping a dependent or optional rider. If you do not make an optional rider selection, you will be given basic coverage only.

Section H: Complete this section only if you are electing the Waiver Buy Out. A Medical Spending Conversion application must also be completed. Contact your personnel/payroll office for information about the Waiver Buy Out Program.

Section J: Your personnel/payroll office must complete this section.

Employees: Return this application to your Agency Benefits Representative, Personnel or Payroll Officer.

Instructions for Completing a Health Benefits Application
(For Retirees)

(Please print all information clearly using a black or blue ballpoint pen)

Check the RETIREE box at the top of the form.

Section A: If you are a NEW retiree, you should only select from the following: Retirement, Disability Retirement, Accident Disability Retirement, Deferred Retirement or Waive Benefits. If you are already covered as a retiree, you should only select from the following: Drop/Add Optional Benefits, Waive Benefits (if you wish to cancel your City coverage) and Reinstatement (if you are requesting to reinstate your City coverage after having previously Waived coverage).

Section B: Check Transfer Period if the change you are requesting is being made during a Transfer Period (such as Adding Optional Benefits or Changing Plans). Check Permanent Move Into/Out of Health Plan Area if you are requesting to change plans as a result of either moving out of the service area of your current plan, or if you are moving into the service area of another plan. Check Retiree Once in a Lifetime if you are requesting to change plans or add optional benefits anytime other than a transfer period.

Section C: Check Spouse Information (Add/Drop) If you are dropping your spouse as a result of a divorce, you must attach a copy of the divorce decree. If you are adding a spouse, you must attach a copy of the marriage certificate or submit domestic partner documentation if adding a domestic partner. Check Dependent (Children) (Add/Drop) if you are adding or dropping a dependent child. If you are adding a dependent child, you must attach a copy of either the birth certificate, or documents proving guardianship or adoption.

Section D: If you are enrolled in Medicare Parts A&B, you must attach a photocopy of your Medicare card. If you are enrolled in another health plan other than your City coverage or Medicare, you must indicate so including the name and policy number of the plan.

Section E: If you are married or have a domestic partner, this section must be completed whether or not you are covering your spouse/domestic partner. If your spouse/domestic partner is enrolled in health plan other than your City coverage or Medicare, you must indicate so including the name and policy number of the plan. If your spouse/domestic partner is enrolled in Medicare Parts A&B, you must attach a photocopy of his/her Medicare card.

Section F: List ALL dependents to be covered. You must indicate yes/no if a dependent is a full-time student. If a dependent is permanently disabled, and on Medicare, you must attach a photocopy of his/her Medicare card.

Section G: Write the complete name of your current health plan or the plan you are selecting (see back of sheet). If you do not make an optional rider selection, you will be given basic coverage only.

Section H: This is the only section in which you are to sign the form. Remember to date your form.

Section I: If you are a NEW retiree (even if you are waiving City coverage), your payroll/personnel office must complete this section.

Retirees: Return this application to: City of New York
Health Benefits Program
40 Rector Street – 3rd Floor
New York, New York 10006
Applicant MUST check only:

□ EMPLOYEE
□ RETIREE

CITY OF NEW YORK
HEALTH BENEFITS PROGRAM

A. Reason(s) for Submission (Check one or more boxes: enter change date if appropriate)

□ New Enrollment
□ Optional Benefits
□ Retiree
□ Additional Benefits
□ Reinstatement
□ Optional Benefits
□ Transfer From Another Agency
□ Cancel Benefits: (Check one)
□ Retirement
□ Waiver Benefits
□ Disability Retirement
□ Buy-Out Waiver Program
□ Accidents Benefits
□ (Employees Only)
□ Complete Sections D, E, F & I only
□ Deferral Retirement
□ Other

B. Transfer of Health Plan and/or Optional Benefits Based on:

□ Transfer Period
□ Permanent Move Into/Out of Health Plan Area
□ Retiree Once In A Lifetime
□ Other

C. Change Of:
□ Date of Event
□ Spouse/Domestic Partner Information
□ Add
□ Drop
□ Dependent Child(ren)
□ Add
□ Drop
□ Change of Name - Former Name:
□ Other

D. Employee/Retiree Information

Last Name
First Name
M.I.
Social Security Number
Tel. No. Work ( )
Home ( )
Apt. No.
Date of Birth
Sex
City
State
Zip Code
Country (If outside the U.S.)
Marital
Status:
□ Single
□ Married
□ Divorced
□ Widowed
□ Domestic Partnership
□ Agency in which Employed or Retired From
□ Union or Welfare Fund
□ Name of Current City Health Plan
□ Are you the contract holder on a non-City group health plan?
□ Yes
□ No
□ If yes* indicate name of plan
□ Policy 
ID or Medicare
□ Claim No.
□ If Medicare, Part A - Eff. Date
□ If Medicare, Part B - Eff. Date
□ Retirement System (If Applicable)
□ Yes, Cred.Svc. (Retirees Only)
□ Retirement Date
□ Pension Number (Retirees Only)

E. Spouse/Domestic Partner Information

Last Name
First Name
M.I.
Social Security Number
Date of Birth
Is your spouse/partner:
□ Employed (check below)
□ Retired (check below)
□ Not Employed (N.Y.C. Agg.)
□ Other
□ Name of Spouse/Partner's Employer
□ Is spouse/partner to be covered by employee's/retiree's?
□ Yes
□ No
□ Does spouse/partner have Non-City group health plan?
□ If yes*, indicate name of plan
□ Policy ID or Medicare Claim No.
□ Individual
□ Family
□ Effective Date
□ If Medicare, Part A - Eff. Date
□ If Medicare, Part B - Eff. Date
□ Is employee/retiree covered by spouse/partner group health plan?
□ Yes
□ No
□ Effective Date
□ If Medicare, Part A - Eff. Date
□ If Medicare, Part B - Eff. Date

F. Family Information (Attach a second form if necessary; dependents may not be covered under two NYC plans.)

List below all family members to be covered or dropped, including yourself. If your plan requires you to choose a specific Medical Group (HGP Plans) or Primary Care Physician (Other HMOs) you must indicate the name and number of the group or physician chosen.

Check if Applicable

G. Health Plan Requested (See reverse side of form for Health Plan names.)

Please refer to the Summary Program Description Booklet for the full name of your health plan.

Health Plan Name in Full:

Please Print

Optional Benefits:

□ Yes
□ No

H. To Participate in the Health Benefits Program - Please Sign and Date Below (Participant Must Sign Either Section H or I)

I certify that the above information is correct and authorize the City to deduct from my salary/earnings the amount required, if any, through the City Health Benefits Program. I understand that the City Program's benefits will be coordinated with those available through Medicare or any other source.

Furthermore, I agree that my periodic health plan deductions, if any, will be made on a pre-tax basis pursuant to the Internal Revenue Code Section 125. I understand that I have the option to decline this benefit, by obtaining a Medical Spending Conversion Form and completing a Medical Spending Conversion Form, both of which are obtainable at my payroll office. (Section 125 does not apply to retirees.)

If I have checked the Waive Benefits box in Section I, I am choosing not to participate in the City Health Benefits Program at this time.

Employee/Retiree Signature

I. To Participate in the Health Benefits Buy-Out Waiver Program - Please Sign and Date Below (Sign Either Section H or I)

I wish to participate in the Health Benefits Buy-Out Waiver Program. I have read the Medical Spending Conversion Health Benefits Buy-Out Waiver Program brochure and completed a Medical Spending Conversion Form and I attest that I meet the qualifications for this program. (Retiree not eligible.)

Employee Signature

J. For Completion by Payroll or Personnel Only

I certify that the above employee/retiree is eligible for the New York City Health Benefits Program (HBP) and that dependent documentation has been verified in accordance with HBP procedures.

I certify that the above employee is eligible for the Health Benefits Buy-Out Waiver Program and I have reviewed and processed the Medical Spending Conversion Form and I attest that the employee meets the qualifications for this program.

Certifying Signature

Date

Agency Code

Title Code No.

Status

□ Full-Time
□ Part-Time

Retired

□ Civil Service
□ Professional

Appointment Date/Rel. Date

Job Seq. No.

Present Health Code

Pay Period

□ Weekly
□ Monthly

Effective Date

□ MO
□ DT
□ YR

Waiver Effective Date

□ MO
□ DT
□ YR

ERB 2000/4/03 SM

Health Plan or Health Benefits Program Copy
DATA SHEET
(please type or print)

TO BE RETURNED TO THE PSC-CUNY WELFARE FUND AT THE ABOVE ADDRESS

I. Name as on CUNY payroll

Last Name

First Name Initial

Social Security No.

If married name differs from that given above, please print your married name on the line below.

Married Name

If you have ever used another name on CUNY records please print it below.

II. Address

House Number and Street

City State Zip Code

III. Home Telephone Number

Area Code

Office Phone Number

IV. Sex Female Male

V. Date of Birth

Month Day Year

VI. Marital Status

Single Married

Widow(er) Divorced

Legally Separated

VII. Indicate NYC Health Insurance Coverage

☐ GHI-CBP ☐ HIP/HMO ☐ GHI Type C ☐ Other ☐

If Health Insurance has been Waived please check ☐

VIII. Rank (Please Check)

Professor Assoc. Assist.

Instructor Lecturer

Other

IX. Department

X. Primary Current CUNY Affiliation

1 Bernard M. Baruch College

2 Bronx Community College

3 Brooklyn College

4 Central Office

5 City College

6 Graduate Studies Division 33 W. 42nd

7 Hostos Community College

8 Hunter College

9 John Jay College of Criminal Justice

10 Kingsborough Community College

11 LaGuardia Community College

12 Herbert H. Lehman College

13 Manhattan Community College

14 Medgar Evers College

15 New York City Community College

16 Queens College

17 Queensborough Community College

18 The College of Staten Island

19 York College

20 Educational Opportunity Center

(Indicate Unit)

XI. At which of the other units in X above, if any, have you had a full-time assignment;

Unit No. From To

XII. Date of Initial continuous Full-Time Employment at CUNY (In Covered Title)

XIII. Current CUNY Annual Salary

Exclude Additional Salary earned in the Evening Session, Summer Session, Etc.

Effective Date 19

Amount $ Signature

Date (OVER)
INSTRUCTIONAL STAFF MEMBER'S PAYROLL NAME

DEPENDENTS FOR PSC-CUNY WELFARE FUND HEALTH INSURANCE PURPOSES

A. Spouse

Last Name ........................................ First Name ........................................ Social Security No. ........................................

Date of Birth ........................................, 19 Relationship of Dependent to you—Wife Husband

Employed: Yes ...... No ...... Employer and Address: ........................................

B. Dependent Children (If unmarried between ages of 19-25 and a full-time student, please indicate college and expected date of graduation.) If not your natural child, indicate in each case whether adopted or stepchild and date.

Last Name ........................................ First Name ........................................ Social Security No. ........................................

Date of Birth ........................................, 19 Relationship of Dependent to you—Son Daughter

Last Name ........................................ First Name ........................................ Social Security No. ........................................

Date of Birth ........................................, 19 Relationship of Dependent to you—Son Daughter

Last Name ........................................ First Name ........................................ Social Security No. ........................................

Date of Birth ........................................, 19 Relationship of Dependent to you—Son Daughter

Last Name ........................................ First Name ........................................ Social Security No. ........................................

Date of Birth ........................................, 19 Relationship of Dependent to you—Son Daughter

Last Name ........................................ First Name ........................................ Social Security No. ........................................

Date of Birth ........................................, 19 Relationship of Dependent to you—Son Daughter

SIGNATURE
The City University of New York

RETIREMENT PROGRAM ELECTION FORM
for Full-Time Instructional Staff/Civil Service Managers

This form is to be used for eligible employees of CUNY who are appointed, promoted, transferred or reclassified to an eligible instructional staff / Civil Service Managerial position and must be filed within 30 days of written notification of eligibility (for new employees, filing must occur within 30 days of appointment). For those electing the Optional Retirement Program (ORP), this election form must be accompanied by a TIAA/CREF Application to complete the election process. Those staff failing to complete the election process within the statutory time frame noted above, are forced into membership with the NYCTRS by law (Civil Service Managers into the NYCERS).

Section 1: Personal Information

Name: __________________________ Social Security Number: __________________________

Address: __________________________

College: ___________ Job Title: ___________ Pension Mem. No. (if any): ___________

Section 2: Election of Retirement Program

Having received written notification of my retirement program options and having satisfied myself as to the desired retirement program available to me by or pursuant to law in connection with my employment by the City University of New York, I hereby make the following election in regard to my participation in the retirement program as specified below: (check one only)

1) _____ The Optional Retirement Program (ORP). I have attached the required TIAA/CREF Regular Annuity Application materials;

2) _____ The New York City Teachers’ Retirement System* (Instructional Staff members only, unless already a member of the NYCTRS through a former position in public service);

3) _____ The New York City Employees’ Retirement System* (Classified Managers only, unless already a member of NYCERS through a former position in public service);

4) _____ The Board of Ed Retirement System* (for current members only);

5) _____ I have been appointed to a Substitute position, and opt not to join the ORP; therefore I choose not to be a member of a pension system at this time.

_________________________________________     ________________________________
Employee Signature/Date                   Verification by Personnel/Date

*Those participating as Transferred Contributors, please check here. __________

pnselec.wpd, 8/98
The City University of New York
Information Regarding Pension System Membership

I. Full-Time Instructional Staff (Including Exec. Comp, REM & Substitute titles):

All full-time instructional staff are eligible for membership in either the Optional Retirement Program (ORP), which refers to membership in TIAA/CREF and the Alternate Funding Vehicles, or the New York City Teachers' Retirement System (TRS). In some cases, an employee who is already a member of the New York City Employees' Retirement System (ERS) and who is appointed to a full-time instructional staff position may retain membership in ERS as a "transferred contributor", thereby revoking his/her rights to join any other public pension plan in the future. Regardless of choice, pension membership, with the exception of Substitutes, is mandatory for all full-time instructional staff. Substitutes can join the ORP only (unless they are Transferred Contributors of another public pension).

New instructional staff who are ERS members on a leave of absence from a civil service position must remain in ERS until they have relinquished their leave, generally upon attainment of 13.3b status in the Instructional staff position. Once this status is attained, the employee has sixty (60) days to 1) elect to remain in ERS, 2) transfer to TRS, or 3) elect membership in the ORP.

Any member of TRS or ERS who is eligible to elect membership in the ORP may be able to retain rights to a TRS or ERS retirement benefit even if normal vesting time frames have not been met, provided contributions to the system are not withdrawn. Please consult with your college personnel office for details.

II. Full-Time Civil Service Managers:

All full-time classified service personnel are required to join the New York City Employees' Retirement System after six months from gaining permanent status (those in provisional status may elect to join earlier). Civil Service Managers are also given the opportunity to join the Optional Retirement Program upon appointment to their position, pursuant to the rules cited in "I." above.

My signature below indicates that I have read the information above and have consulted with my college personnel office regarding any questions I may have had concerning my pension program options and rights.

Name  Signature/Date  Personnel Office Verification

The information provided within this document is based upon currently available information and should not be considered the sole source of information regarding pension membership. In all cases, the provisions of governing laws, rules and regulations prevail.

(please attach to CUNY "RETIREMENT PROGRAM ELECTION FORM")
CHOOSING A PENSION PLAN: A GUIDE FOR NEW MEMBERS

New York State law mandates participation in a retirement system for full-time members of the instructional staff. New staff members have 30 days from the effective date of their appointment to choose a retirement program, and the choice is irrevocable. If no choice is filed within 30 days, the law mandates that the member be assigned to the New York City Teachers' Retirement System. Full-time instructional staff members may choose between the New York City Teachers' Retirement System (TRS) and the Optional Retirement Program (ORP). Those who elect the optional retirement program may choose investment options through the Teachers Insurance and Annuity Association-College Retirement Equities Fund (TIAA-CREF) and the alternative funding vehicles offered by The Guardian or MetLife. More information may be obtained from the college personnel office. Adjuncts employed by CUNY are only eligible for membership in TRS and may join at their option.

Additional information on choosing a pension plan is available by contacting Clarissa Gilbert Weiss, director of pension and welfare benefits, PSC, 25 West 43rd Street, New York, NY 10036 (212/354-1252) or send email to psc1@bway.net.

The following chart comparing the two systems has been prepared to assist new members to choose their pension plan.

<table>
<thead>
<tr>
<th>CUNY's Pension Systems</th>
<th>New York City Teachers' Retirement System (TRS)</th>
<th>Optional Retirement Program Tier V**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Plan</strong></td>
<td>Defined benefit plan: Benefits are based on age, consecutive three years' average salary and years of employment.</td>
<td>Defined contribution plan: Benefits are based on the amounts contributed by the employer and employee and the success of the employee’s choice of investments.</td>
</tr>
<tr>
<td><strong>Vesting</strong></td>
<td>5 years</td>
<td>After first reappointment. (Immediate if employee has an open TIAA-CREF Contract.)</td>
</tr>
<tr>
<td><strong>Retirement Age</strong></td>
<td>Minimum 55 and 5 years of credited service at an actuarially reduced rate or age 55 with 30 or more years of service with no reduction.</td>
<td>Member may choose to retire and begin annuity income any time. However, city-provided health benefits are not available to individuals with less than 15 years of full-time CUNY service.</td>
</tr>
<tr>
<td><strong>Contribution Rates</strong></td>
<td>For the first 10 years of public employment employee pays 3% of regular compensation on a federally tax-deferred basis. Employer contributes a lump-sum annually to its pension funds, not to individual accounts. The annual amount is determined by the actuary of the pension systems.</td>
<td>Employee pays 3% of base salary on a federally tax-deferred basis. Employer pays 8% of salary for first seven years of employment and 10% thereafter.</td>
</tr>
</tbody>
</table>
| **Retirement Allowance**| Less than 20 years or service: \(1.67\% \times \text{Final Average Salary (FAS)}: \text{average wages paid for three consecutive years} \times \text{years of service.}
20 to 30 years of service: \(2\% \times \text{FAS} \times \text{years of service.}
Over 30 years of service: Additional 1.5% after 30 years \times \text{FAS} \times \text{years of service after 30.}
Retirement benefits are based on total accumulations, age at retirement, and the income option selected. |
| **Disability Benefits** | A member of TRS is eligible to retire for Ordinary Disability if he or she has 10 or more years of service credit. Benefit schedules and formulas are spelled out in the laws relating to Tier IV. | A member who has been certified disabled may receive annuity payments and city-provided health benefits after 10-years of full-time service. |
| **Death Benefit**       | 1/12 of last year's earned salary \times \text{years of service to a maximum of 36 years. Or one year's salary \times years of service to a maximum of 3 years which is reduced actuarially after age 61.} | Total amount in pension and SRA accounts. |
| **Loans**               | Yes, on member contributions and TDA accumulations. | Yes, to the maximum allowable by law on both the Pension & SRA. |

*Individuals appointed on or after Sept. 1, 1983

**Individuals appointed after July 17, 1992
Sexual Harassment

Panel Coordinator; Deputy; Members

Haynes, Michael (Coordinator) President’s Office
Bing, Vanessa (Deputy) Women’s Center
Ingram, Michele Security
Lane, Deborah Allied Health Sciences
Lorde, David Mathematics
McDonald, Thomas Students With Disabilities
Padula, Mary Business Management
Sharpe, Maya Developmental Skills

Director of Affirmative Action & Compliance (HEO)
Director of Women’s Center (HEO)
Asst. Director Campus Safety & Security
CUNY Office Assistant, Level IV
Sr. College Laboratory Technician
Director of Students with Disabilities (HEa)
Associate Professor
Associate Professor

Education Committee Members

Aymer, Samuel Social Science/Human Services
Chao, Gloria Human Resources
Hayes, Cassandra M. Human Resources
Levinson, Kenneth Developmental Skills
Maldonado, Acte Continuing Education
Rumayor, Sandra Academic Affairs
Schmitz, William Security

Assistant Professor
Assistant Director of Human Resources (HEA)
CUNY Administrative Assistant, Level II
Associate Professor
Dean of Adult & Continuing Education
Director of Partnerships & Collaboratives (HEA)
Director of Campus Safety & Security
BOROUGH OF MANHATTAN COMMUNITY COLLEGE
The City University of New York
IMMIGRATION REFORM AND
CONTROL ACT OF 1986

EMPLOYMENT ELIGIBILITY VERIFICATION INFORMATION

Among other changes, the Immigration Reform and Control Act of 1986 creates a national employment verification system which places responsibility for verification of the identity and employment eligibility of all employees on the employer. Effective June 1, 1987 this new law requires employers to request and examine original documentation pertaining to the identity and employment eligibility of all new hires and rehires, including U.S. citizens, permanent residents, and non-immigrant visa holders.

Should you accept an offer of employment with the Borough of Manhattan Community College, you must present ORIGINAL documentation outlined on the reverse side of this document on or before your first day of work.

After these documents are reviewed, you will then be required to complete and sign an Employment Eligibility Verification Form (Form I-9) in the presence of the designated representative of the College.

Should you accept an offer of employment with the College, this process should be completed on or before your first day of work. Otherwise, your employment at the College will be jeopardized.

If you have any questions concerning the employment process at Borough of Manhattan Community College, please call the Human Resources Office, 212-220-8300.
One of these ORIGINAL documents to establish identity, and employment eligibility:

- U.S. passport;
- Certificate of U.S. citizenship (INS Form N0500 or N-561);
- Certificate of Naturalization (INS Form N-550 or N-570);
- Unexpired foreign passport with unexpired official stamp or valid Form 1-94.
- NOTE: Use of this form must first be verified.
- Alien registration receipt card with bearer's photograph ("green card"-INS form I-151);
- Resident alien form with bearer's photograph (INS Form I-155);
- Temporary resident card (INS Form I-688)
- Employment authorization card (INS Form I-688A).

If you do not have any of the above documents, then you must present one document from each of the next two sections:

One of these ORIGINAL documents to establish identity:

- State-issued driver's license or state-issued identification card containing a photograph
  or if the document does not contain a photograph, identifying information such as name,
  date of birth, sex, heights, color of eyes and address;
- School identification card with a photograph;
- Voter's registration card;
- U.S. military card or draft record;
- Identification card issued by federal, state, or local government agencies or entities;
- Military dependent's identification card;
- Native American tribal documents;
- U.S. Coast Guard Merchant Mariner card;
- Driver's license issued by a Canadian government authority.

AND

One of the ORIGINAL documents to establish employment eligibility:

- Social Security number card other than on which has printed on its face "not valid for
  employment purposes";
- Certification of birth issued by Dept. of State (Form FS-545)
- Original or certified copy of birth certificate issued by a state, county, or municipal
  authority bearing a seal;
- Certification of birth aboard issued by Dept. of State (Form DS-1350);
- Unexpired reentry permit (INS Form 1-327);
- Unexpired Refugee Travel document (INS Form 1-571);
- Employment authorization document issued by the INS;
- Native American tribal document;
- U.S. citizen identification card (INS Form 1-197);
- Identification card for use of resident citizen in the U.S. (INS Form 1-179).
TO: CANDIDATES FOR ADJUNCT POSITION

FROM: HUMAN RESOURCES

SUBJECT: APPOINTMENT AND PAYROLL PROCESSING

When you accept an offer employment with the Borough of Manhattan Community College, you must present ORIGINAL documents as outlined in the attached.

Under federal law, you are required to complete and sign an Employment Eligibility Verification Form (Form 1-9) in the presence of a designated representative in the Human Resources Office, Room S-710. This process must be complete by the third day of the semester. We strongly recommend that you complete the 1-9 before your first day of work.

In addition, other documents for your appointment include the following:

1. All appointment forms (see attached).
   The Constitutional Oath is required for employment

2. Your resume;

3. Two reference letters;

   This original transcript must have the seal of the institution. Transcripts are not required for Adjunct College Lab Technicians;

5. Social Security Card.

The timing of your initial salary check will be based on the above process and our receipt of the completed Personnel Action Form (PAF) from your department. If you have any questions about the appointment or payroll process, please call us at (212) 220-8300.

Thank you.

/kb/
Attachment

9/02 - HR