CITY OF NEW YORK

NEW EMPLOYEE HIP HMO OPT-OUT REQUEST FORM

Pursuant to the New York City Health Benefits Summary Program Description, all City of New York employees, and employees of Participating Employers, hired on or after October 1, 2022 will only be eligible to enroll in the EmblemHealth HIP HMO Preferred Plan and must remain in the HIP HMO Preferred Plan for the first 365 days of employment.

An employee who needs to request an exemption to this requirement can do so by submitting this completed Opt-Out Request Form to EmblemHealth, via the email address provided below. An employee or eligible dependent must meet the criteria outlined below, and the request must be approved by EmblemHealth before the exemption is granted.

Criteria for Opt-Out (Check box below):

- ☐ If the new employee resides outside of the HIP HMO service area and cannot access primary care with one of the HMO providers. Visit https://www.emblemhealth.com/Members/City-of-New-York-Employees for a list of counties in HIP HMO Service Area. Please provide your name and address on the back of this form.

- ☐ If the new employee or eligible dependent is being treated by a non-network provider for a life-threatening or disabling disease or condition and is receiving ongoing treatment for a catastrophic or terminal illness or has a condition that requires complex case management (such as ventilator dependence or trauma). Please provide treating physicians name, address and phone number on the back of this form.

Process:

New employees need to complete and submit this New Employee HIP HMO Opt-Out Request Form immediately. *Please email completed* forms *to:* cityagencies@emblemhealth.com or fax *to 212-510-5919.*

Once your Opt-Out Request Form has been reviewed and a determination has been made, *you will be notified by EmblemHealth via the email* address *you have provided on the back of this* form. *If you* are *approved, you must submit the approval notification to NYCAPS* or *your agency benefits representative.*

Please complete the following:

Employee Information

Employee Last Name: _____ *Employee First* Name: _____

Date of *Birth:* _____ *Phone:* _____

Email Address: .....

Home Address: _____ *Home Zip:* ___ _

Agency: _____ *Date* of *Hire:* _____

Dependent Information:

(If the request for exemption is due to an eligible dependent, please also provide the following.]

Dependent's Last Name:_____ *Dependent's First* Name:_____

Dependent's Date of *Birth:* _____

Medical Information

Please check one:

- D Self
- □ Dependent

Treating Physician's Name: _____

Physician's Phone: _____

Physician's Address: _____

Diagnosis/Condition: _____

EMPLOYEE/DEPENDENT'S SIGNATURE AND RELEASE ***(this form must be signed to be processed)***

I hereby request exemption from the above City Health Benefits Program requirement and certify that the above information is complete, true and correct. I authorize above listed physicians and other medical professionals to provide EmblemHealth with information concerning medical care, advice, treatment or supplies provided to the Employee or eligible dependent. I understand that this authorization will be used only for the purpose of obtaining information, and the duration of the authorization will be limited, to determine whether the employee or eligible dependent meets the criteria outlined above. I agree that a photostatic copy of this authorization is as valid as the original.

Employee Signature: _____ Date: _____

Dependent's Signature (if dependent is not a minor) _____ Date: _____

FOR OFFICIAL USE ONLY
• Approval
• Denial - does not meet criteria
Date: