City of New York

New Employee MetroPlus GOLD Opt-Out Request Form

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: ☐ **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 MetroPlus GOLD Preferred Plan 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**

First Name: _____ **Last Name:** _____ **Title:** _____

Signature: _____ **Date:** _____

Process:

New employees need to complete and submit this New Employee MetroPlus GOLD Opt-Out Request Form immediately. Please email completed forms to**: mphr@metroplus.org** or fax to **212-908-5192.**

Once your Opt-Out Request Form has been reviewed and a determination has been made, you will be notified by MetroPlus Health Plan via the email address you have provided. If you are approved, you must submit the approval notification to your benefit representative. This form will be received and processed in accordance to all applicable federal and state laws and regulations on the guarding of personal health information (PHI).