AONY Information Form for Temporary Employees and Employees of Participating Institutions Scheduled to Work Less Than 30 Hours per Week

Temporary employees *and* employees who are regularly scheduled to work less than 30 hours per week are required to complete a ***Information Form for Temporary Employees and Employees of Participating Institutions Scheduled to Work Less Than 30 Hours Per Week form.*** ***(Do not include volunteers on this form)*

The Benefits Administrator/Human Resources Coordinator/ Employer Representative completes the Employer's Section of the form and fax, emails or mails it within 10 days of the employees date of hire to:

Employee Benefit Connections
1011 First Avenue, Room 1654
New York, NY 10022
Fax Number: 212 644 0690
Email: EBC@archny.org

When a part time and/or temporary employee stops working for a group or institution, the employer/benefits administrator **must submit** a **Termination Transmittal** to the Employee Benefit Connections department in to terminate the benefits promptly.

For further assistance, the employer/benefits administrator should contact the Employee Benefit Connections department at **646 794 3060**.

Note:** Effective **January 1, 2017,** Non Bargaining Lay employees must be regularly scheduled to work at least ***30 hours per week in order to be eligible for group health benefits. (Does not apply to Bargaining Lay Faculty members who are regularly scheduled to work at least **20 hours** per week.)

******Volunteers*** *are not considered employees and should not be included on this form).*

INFORMATION FORM FOR TEMPORARY EMPLOYEES AND EMPLOYEES OF PARTICIPATING INSTITUTIONS SCHEDULED TO WORK LESS THAN 30 HOURS PER WEEK

Note: Please return your completed form to your Local Benefits Administrator within 30 days of your date of hire.

Please indicate the reason you are completing this form:

❑ New Hire ❑ Work Hours Change ❑ Update Salary ❑ Name Change ❑ Address Change ❑ Other__________________
(Please indicate)

Last Name____ First Name______________________ MI____
Social Sec. #:_________-_________-__________ Date of Birth_____/______/______ Gender: ❑ Male ❑ Female
Home Address: Street____ Apt. No.________
City____ State__________ Zip___________
Home Phone__________________________ Work Phone______________________
Occupation______________________________ Covered by Collective Bargaining Agreement: ❑ Yes ❑ No
Date of Hire_____/_____/_______ Regular Weekly Work Hours_______ Salary $___________ Eligible to work in the U.S: ❑ Yes ❑ No

EMPLOYER INFORMATION

Employer (Institution) ____________________________________ Institution No. _____ Division Code______
Employer Street Address____
City______________________________ State_____ Zip Code________ Phone______________________

All information provided is complete and true to the best of my knowledge. Knowingly submitting false information with intent to defraud may constitute a fraudulent act under applicable law, which may subject a person to civil or criminal penalties.

Employee/Participant Signature (Required):____ Date: ____________

Employer's Signature (Required):____ Date: ____________

Employer Print Name (Required):____

LOCAL ADMINISTRATOR: Please return this form to: Employee Benefit Connections, 1011 First Ave, Suite 1654, New York, NY 10022, Telephone: 646.794.3060 or Fax: 212.644.0690

Contact us: **ebc@archny.org** **Web Page:** **www.archny.org/benefits/**