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________________________________ City_____________ State _______ Apt. No. __________
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/

Information Form  Revised 01/01/2018