

Spouse's Information Upon Death of a Retiree

Upon the Death of a Retiree call the Notification Desk of the NYC Fire Department at **(718) 999-2094** and give them the following information;

Name of Member:	Address of Member:
Soc Sec #:	
Pension #:	Spouse Name:
Appointment Date:	Phone #:
Retirement Date:	
Company Appointed to:	Funeral Home Name:
Company Retired From:	
	Address:
Rank:	Phone #:
Faith of Member;	Viewing Dates & Times:
Date of Birth:	
Date of Death:	Name of Church:
	Address:
Call Members unit:	Date & time of Service:
Phone #:	Cemetery Name;
	Address:

A **Funeral Escort** may be requested only within NYC Limits.

Also Notify:

FDNY Pension Bureau. (718) 999-2320A
 Uniformed Firefighters Assoc (212) 683-4723 **or**
 Uniformed Fire Officers Assoc (212) 376-8400

Pension Check

Do not cash or if direct deposit, spend the last pension check. Checks are issued on 1st of month for the current month. You may have to return the portion from date of death to end of the month. For example, if death occurs on June 10th, the amount for the remaining 20 days will have to be returned.

Death Certificates are needed for the following;

FDNY Pension, Fire Union, Social Security, Deferred Compensation Plan, Insurance Policies, Department of Motor Vehicles, Veterans Administration, Financial Institutions, Lawyer

Marriage Certificates are required for Social Security and Veterans Admin.

Discharge Papers are required for Veterans Administration (800) 827-1000

Health Insurance

P8/3/05

Health Insurance ends upon death of Retiree unless he retired with a Line of Duty Disability Pension and his death was a result the ailment he retired from. In that case the spouse should contact the Pension Section notifying them of the cause of death and request them to continue her health coverage.

All others are eligible to purchase COBRA health insurance coverage. COBRA coverage may be for only for a limited period of time. COBRA must be applied for within 60 days or eligibility.

Spouses now have the ability to purchase health coverage through the NYC Health Benefits Fund at a cost of 102% of the group rate. This must be applied for within one year of eligibility. (As of 7/04 – for an individual on Medicare, GHI without rider costs \$131 per month)

The UFA will provide the spouses Health Insurance and Security Benefit Fund coverage for one year after death. The UFOA does not provide this coverage. Coverage can be purchased from the union.

If Retiree was on Medicare notify NYC Health Benefits Fund requesting reimbursement of current year Medicare Part B payments. (Affidavit follows)

If member had Catastrophic Health Insurance through the union, it may be continued to be purchased by the spouse. Contact the Catastrophic insurance provider.

It is important that you **Contact the Union** for additional information and assistance.

See Form Section

Life Insurance

NYC and the UFA and UFOA have a death benefit that covers the Retiree.

A NYC Death Benefit of \$5,800 will be paid to the beneficiary. Processing starts with FDNY notification.

The UFA Security Benefit Fund and the UFOA Family Protection Plan have a death benefit that covers their members. The amount varies according to the age of the Retiree. Processing starts with union notification.

The Retiree also may have opted to purchase additional insurance through their respective union.

UFA/UFOA Annuity Fund

The Retiree may still have had an account with the UFA or UFOA Annuity Fund. Contact the respective union for additional information.

Deferred Compensation Plan

If the Retiree had an account with the NYC Deferred Compensation Plan notify them of members death and arrange for disposition of remaining funds.
(212) 306-7760, (888) DCP-3113

Changing Health Plans

P4/1/03

Retirees may transfer Health Plans or add an Optional Rider during the even-numbered year Transfer Periods. The transfer period is **October of even numbered years** and is effective January 1st.

Additionally, retirees who have been retired for at least one year can take advantage of a once-in-a-lifetime provision to transfer or add an optional rider at any time. Once-in-a-lifetime transfers become effective on the first of the month following the date that the Health Benefits Application is processed.

If you permanently move outside of your plan's service area, you may transfer within 31 days to another plan without waiting for the next Transfer Period. Also, if you move into the service area of a plan, you may transfer within 31 days to that plan.

Forward a Health Benefits Application to the NYC Health Benefit Program. Form with instructions can be downloaded from their web site [Application Form](#)

You or Your Spouse Becomes Eligible for Medicare 4/1/03

When you or your spouse becomes eligible for Medicare, Medicare provides your first level of benefits. The NYC Health Benefits program is your secondary coverage. The Health Benefits Program supplements Medicare but does not duplicate benefits. **You must join Medicare Part A & B as soon as you are eligible.** If you do not join you will lose whatever benefits Medicare would have provided. Contact Social Security 3 months prior to turning 65.

You must notify the NYC Health Benefits Program in writing (Application Form Section D or E) immediately upon receipt of your or your dependent's Medicare card. Include the following information: a copy of the Medicare card and birth dates for yourself and spouse, retirement date, pension number and pension system, name of health plan, and name of union welfare fund.

The Health Benefits Program will notify your health plan that you are enrolled in Medicare so that your benefits can be adjusted.

Once the Health Benefits Program is notified that Medicare covers you, will automatically receive the annual Medicare Part B premium reimbursement

You should also notify your union of Medicare eligibility. Additional information may be obtained on the NYC Health Benefits Web Site. [Medicare Information](#)

Reimbursement of Medicare Part B

AFFIDAVIT

To obtain reimbursement for Medicare Part B payments made by a deceased person, and/or reimbursement for enrollment in a Medicare risk plan, if applicable, without court administration.

Deceased' Name : _____

Deceased's Social Security # _____

City agency from which deceased retired: _____

State of _____ and County of _____

_____, being duly sworn, deposed and says:

(your name)

I bear the indicated relationship to the deceased, _____

(deceased's name)

(Put a check mark in the appropriate bracket)

Surviving spouse Brother or Sister

Child, 18+ years of age Parent

Other, explain: _____

Said deceased died on _____ (date), at _____

_____. (place). (Get from death certificate).

More than 30 days have elapsed since said decedent's death.

At the time of deceased's death, he/she was a permanent resident at

_____: County of _____ (give full address).

At the time of death, there was due and owing to the estate of deceased, from the City of New York Pursuant to section 12-126 et seq of the New York Administrative Code, a sum of less than \$1,200 which constitutes claimed reimbursement for Medicare Part B premium payments which were paid by the deceased and/or reimbursement for enrollment in a Medicare risk plan, if applicable.

6. I make this affidavit to obtain said payment in full satisfaction of said indebtedness of the City of New York to the estate of the deceased. The name and address of the person entitled to, and who will receive such money paid as follows:

Name: _____

P 5/04

Mail to: Health Benefits Program
40 Rector Street, 3rd floor
New York, NY 10006

Spouse Request to Continue Health Coverage

Widows who wish to continue their health coverage should use form below and send to Rector St. It may be wise to enclose a self-addressed stamped envelope. Use the following format and mail info to:

City of New York
Office of Labor Relations
Employee Benefits Program
40 Rector St., NYC, NY 10006
ATTN: Honorable James F. Hanley, Commissioner
Dorothy A. Wolfe, Director
Reference: NY State Chapter Law 436

Dear Sir or Madam:

I hereby notify you that I wish to participate in the health insurance program afforded to a surviving spouse of a deceased retired New York City Firefighter (member FDNY) as provided under New York State Chapter Law 436, paragraph (ii).

I understand this Law allows me to continue in the existing insurance coverage that was provided to my spouse; that I may continue this coverage for the rest of my life and that I will pay 102% of the COBRA premium.

Please enroll me in the Chapter Law 436 continuation of permanent health Insurance coverage.

Your confirmation to me in writing that I have been enrolled in the program will be greatly appreciated.

Very Truly Yours,

Signature Date

Name (Print)_____

Address_____

Date of Birth _____ Social Security No. _____

(Deceased) Spouse Name (Print) _____

Date of Birth _____ Date of Death _____

Social Security No. _____