



Initial Letter Draft – 8.3.2026 – sent to MLC

C/O HMS - Dependent Verification
PO Box 165308
Irving, TX 75016-9923



DATE



PC or Mobile Upload: www.VerifyOS.com



FAX: 877-223-8478



Go green at www.VerifyOS.com

Emp_Name
Street
Street2
City, St Zip

EID

REFERENCE NUMBER: EID

RESPOND BY: DATE

Dear Emp/Ret. Name,

IMPORTANT NOTICE: Action Required to Maintain Health Insurance Coverage for Your Dependents

The New York City Health Benefits Program has partnered with an independent firm, Health Management Systems, Inc. (HMS) to verify that all dependents enrolled in the NYC Health Benefits Program meet the City's eligibility guidelines for City health insurance benefit coverage.

To ensure your dependent(s) continue to receive health benefits under the NYC Health Benefits Program, **action is required by you to submit proof of their eligibility, and failure to submit proof will result in termination of their City health insurance coverage.** You must complete and return the enclosed Verification Form with the Required Documents **by *Verification Deadline***.

As a reminder, eligible dependents are defined in the City's Health Benefits Summary Program Description (SPD) as:

- Your legally married spouse,
- Your registered Domestic Partner,
- Your *child** up to age 26, and
- Coverage may be continued for an unmarried child of any age who is incapable of self-support due to a mental or physical disability.

*A *child* is defined as your natural biological child, stepchild, legally adopted child or child placed with you for adoption, a child for whom you or your spouse has been appointed the legal guardian, or a child for whom you are required to provide health insurance by a Qualified Medical Child Support Order.

Thank you for your cooperation in protecting the integrity of the health benefits program for all participants.

If you have questions or are having any difficulty understanding this material, call HMS at (XXX) XXX-XXXX, Monday through Friday from 8:00 a.m. to 8:00 p.m. ET, or visit us online at www.VerifyOS.com. HMS can provide assistance in any language by using its language line service.

You can also view this information in your preferred language by visiting the Health Benefits page on the Office of Labor Relation's website at nyc.gov/hbp and selecting Translate in the top right corner of the page.

REQUIRED DOCUMENTS

All required documents **MUST** contain the date (including year), employee's/retiree's name, and dependent's name. Personal information such as Social Security Numbers, account numbers, and financial information may be marked out for confidential purposes. Please **DO NOT** mail original documents as they will not be returned.

Please include a copy of the Verification Form signed and dated along with all required documentation submitted.

FOR SPOUSE:

- A copy of your government-issued marriage certificate **AND**
- **One of the following:**
 - A copy of the front page of your 2025 federal tax return confirming the dependent is your spouse
 - A document dated within the last 90 days showing current relationship status such as a recurring monthly household bill or statement of account (i.e. utility bill, mortgage/bank statement, etc.). The document must list your spouse's name, your mailing address and the statement/issue date. Note: Healthcare bills will not be accepted as proof of eligibility as healthcare coverage is being verified.

FOR DOMESTIC PARTNER:

- A copy of your government-issued certificate of domestic partnership **AND**
- A document dated within the last 90 days showing current relationship status such as a recurring monthly household bill or statement of account (i.e. utility bill, mortgage/bank statement, etc.). The document must list your partner's name, your mailing address and the statement/issue date. Note: Healthcare bills will not be accepted as proof of eligibility as healthcare coverage is being verified.

FOR CHILDREN UP TO AGE 26 AND DISABLED CHILDREN:

- A copy of the child's government-issued birth certificate or adoption certificate naming you or your spouse/partner as the child's parent. Please note the document must list the first and last names of the child and parent(s), **OR**
- A copy of the Court order naming you or your spouse/partner as the child's legal guardian.

Note for a stepchild: If you are covering a stepchild or child of your domestic partner, you must also provide documentation of your current relationship to your spouse or domestic partner as requested above.

*Did you know VerifyOS** is available on your phone or tablet? Enter www.VerifyOS.com into your mobile browser to quickly check status or easily upload photos of your documents.*

Verification Form**Return this form with the required documentation**

**** VerifyOS is a secure online platform that allows you to check the status of your covered family members and securely upload required proof of eligibility (see the Document Requirements above for details). To use the portal, you will need the unique reference number provided in this letter.**

Name: Emp_name**PC or Mobile Upload:** www.VerifyOS.com**Reference Number:** EID**FAX:** 877-223-8478

According to our records, the following dependent(s) are currently enrolled in your health plan:

Enrolled Dependent Name Relationship	Does this person meet the definition of an eligible dependent?		If not eligible, please indicate the reason for ineligibility.
	YES	NO	
dep_1	☐	☐	
dep_2	☐	☐	
dep_3	☐	☐	

For dependents that do not meet the definition of an eligible dependent, no documentation is required and the ineligible dependent will be removed from your NYC Health Benefits coverage.

To complete the verification process for eligible dependents, simply follow these steps:

- Collect copies of all **required documents** (listed on page 2) for each enrolled dependent.
- **Sign** and **date** the signature box below.
- Submit **this form** and copies of all **required documents** to HMS by ***Verification Deadline***. Please ensure a copy of this form is included with all documents submitted.
- For faster processing, please submit required documents by uploading them via the secure web portal using your computer or mobile device at www.VerifyOS.com, or by faxing them to 877-223-8478.
- If the web and fax are unavailable to you, documents may be mailed to HMS, P.O. Box 165308, Irving, TX 75016-9923. **Please DO NOT mail original documents as they will not be returned.**

By my signature on this form, I certify to the NYC Health Benefits Program that (1) all information on this form is true, correct, and current as of the date signed and (2) all **"REQUIRED DOCUMENTS"** that are submitted are authentic.

Signature of Employee/Retiree: _____ **Date:** _____