



**BENEFITS OFFICE  
806 CITY HALL  
BUFFALO NY 14202**

**NEW EMPLOYEE  
BENEFITS PACKAGE**

**UNION AFFILIATION: BTF**

**If you have any questions please contact us at:**

**Telephone: (716) 816-3754**

THE FOLLOWING FORMS ARE REQUIRED TO ESTABLISH YOUR BENEFITS:

1. Group Life Insurance Enrollment Form (no cost to you)

- See attachment for details

2. Health Insurance Enrollment Form\*

- Review the enclosed health insurance comparison chart.
- Call the Benefits Office to request the Health Insurance Application of your choice.
- The application will be processed upon your approval by the Board.
- **If you are receiving health insurance coverage from another source**, you are eligible to participate in the waiver program, which entitles you to \$100 per month in-lieu of health insurance. Contact the Benefits Office at 816-3754 for a **Waiver Program Enrollment Form** and details.

*\*Family health coverage requires:*

- For Spouse – a copy of page 1 and 2 of your Federal Tax Return (black-out all financial information) or a copy of your marriage certificate (if married during the current year)
- For Dependent Children – copies of birth certificates

3. Employee Acknowledgement

- Information concerning COBRA /HIPAA /Employee Responsibility

DENTAL & VISION BENEFITS - contact the Buffalo Teachers Federation at 881-5400

OPTIONAL BENEFITS

❖ Direct Deposit

- A Payroll Form has been included for your convenience.

❖ 403(b) Tax Shelter Annuity or NYS Deferred Compensation Account\*

- Contact company of your choice. See attached listing of approved annuity companies.

❖ Flexible Spending Account\* (a tax shelter for unreimbursed medical and dependent care expenses)

- Completed application must be returned within thirty (30) days of your hire date or wait for open enrollment in November.

\*For more information please visit our website at [www.buffaloschools.org](http://www.buffaloschools.org). Go to Human Resources; Benefits/Workers Comp.



**BUFFALO TEACHERS FEDERATION  
LIFE INSURANCE ENROLLMENT/CHANGE FORM**

**Guardian Life Insurance  
Northeast Regional Office  
PO Box 26040  
LehighValley, PA 18002-6040**

**Plan Holder: Buffalo Board of Education  
Group Plan Number: 334052**

**Coverage: Basic Life (with Accidental Death & Dismemberment)**

CLASS	AGE	VALUE
11	Age 70 and older	\$1,000
12	Age 60 but less than 70	\$3,600
13	Age 50 but less than 60	\$6,000
14	Less than age 50	\$12,000

**EMPLOYEE INFORMATION**

LAST NAME	FIRST NAME	MIDDLE INITIAL	
STREET ADDRESS	CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	TELEPHONE NUMBER	

**Marital Status:**    Single    Married    Divorced    Widowed

**BENEFICIARY DESIGNATION:**

**(Include full proper name and relationship; i.e. Meryl M. Klein, Husband)**

**NAME:** \_\_\_\_\_ **RELATIONSHIP TO YOU:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

I hereby apply for the group benefit(s) indicated above. I know my coverage will not take effect unless I am actively at work and life insurance coverage for my dependents will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex. I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if contributions are required for the insurance. The information provided above is true and correct to the best of my knowledge. Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

\_\_\_\_\_  
**SIGNATURE OF EMPLOYEE**

\_\_\_\_\_  
**DATE**

For questions specific to coverage contact: Blue Cross @ 887-8880 or 1-888-299-2263

### Plan Comparison - BTF

CATEGORY	Plan A - BC/BS Traditional	Plan B - Plan of benefits formerly offered through IHA	Plan C - Plan of benefits formerly offered through Univera	Plan D - BC/BS POS Community Blue
<b>Surgeon/Anesthesiologist Fees (Inpatient/Outpatient)</b>	Covered. Participating doctors accept payment as payment in full.	Covered in full.	Covered in full.	Covered in full.
<b>Doctor's Fees for Maternity Care</b>	Covered. Participating doctors accept payment as payment in full.	Covered in full.	Covered in full.	Covered in full.
<b>Cosmetic Surgery</b>	Covered when required and necessary as determined by the insured's physician	Elective cosmetic surgery is not covered. We will, however, provide coverage for services in connection with reconstructive surgery per BCBSWNY medical guidelines.	Elective cosmetic surgery is not covered. We will, however, provide coverage for services in connection with reconstructive surgery per BCBSWNY medical guidelines.	Elective cosmetic surgery is not covered. We will, however, provide coverage for services in connection with reconstructive surgery per BCBSWNY medical guidelines.
<b>Doctor's Hospital Visits</b>	Covered for 365 daily visits. Participating doctors accept payment as payment in full. Further visits covered by Major Medical.*	Covered in full.	Covered in full.	Covered in full.
<b>In-Hospital Consultations</b>	Covered. Two per admission. Participating doctors accept payment as payment in full. Further consultations may be approved or will be covered by Major Medical.*	Covered in full.	Covered in full.	Covered in full.
<b>Emergency Services</b>	Hospital charges covered in full. Surgical procedures and related services covered. Covered in full up to \$100 per calendar year, with additional benefits under Major Medical.	\$35 copayment for emergency room. Copayment is waived if admitted.	\$25 copayment for worldwide emergency room use. Copayment is waived if patient is admitted.	\$35 copayment for worldwide emergency room (ER) use including physicians' fees for life threatening emergencies. Copayment for emergency room waived if admitted.

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CATEGORY	Plan A - BC/BS Traditional	Plan B - Plan of benefits formerly offered through IHA	Plan C - Plan of benefits formerly offered through Univera	Plan D - BC/BS POS Community Blue
<b>Well Child Care</b>	Initial newborn exam and the first 6 well child visits covered for the baby's first year, when using a participating provider. Additional visits covered through age 19.	Covered in full.	Covered in full.	Covered in full.
<b>Diabetic Supplies</b>	Insulin, oral agents, equipment, and supplies covered after deductible and 20% copayment. For Major Medical type riders with a separate prescription drug card, member may either pay prescription drug copayment or Major Medical copayment after deductible, whichever is less.	Diabetic durable medical equipment - \$8 copayment. Diabetic supplies up to a 30 day supply - \$8 copayment. Insulin up to a 30 day supply - \$8 copayment or RX copayment, whichever is less.	Diabetic durable medical equipment - \$5 copayment. Diabetic supplies up to a 30 day supply - \$5 copayment. Insulin up to a 30 day supply - \$5 copayment or RX copayment, whichever is less. No copay for dependents under age 19.	Diabetic equipment and supplies subject to \$5 copayment. Insulin and oral agents are covered, subject to prescription drug or office visit copayment, whichever is less. Certain items are subject to prior approval.
<b>Outpatient X-Ray</b>	Covered. Participating doctors accept payment as payment in full.	Covered in full.	\$5 copayment. No copayment for dependents under age 19.	Covered in full.
<b>Outpatient Laboratory and Pathology</b>	Covered. Participating doctors accept payment as payment in full.	Covered in full.	Covered in full.	Covered in full.
<b>Alcohol &amp; Substance Abuse Inpatient</b>	Detoxification is covered in full. Rehabilitation is not covered.	Detoxification covered in full. Rehabilitation is not covered.	Detoxification covered in full for up to 7 days. Rehabilitation is not covered.	Up to 30 days per member per year of inpatient hospitalization for detoxification covered in full. Inpatient rehabilitation is not covered.
<b>Alcohol &amp; Substance Abuse Outpatient</b>	Covered for up to 60 outpatient visits per calendar year covered. Participating doctors accept payment as payment in full.	\$8 copayment for up to 60 outpatient visits per member per calendar year.	\$5 copayment for up to 60 outpatient visits per member per calendar year.	\$10 copayment for 60 visits per member per calendar year.
<b>Ambulance</b>	Covered in full when medically necessary.	Covered in full when medically necessary.	Covered in full when medically necessary.	Covered in full when medically necessary.

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CATEGORY	Plan A - BC/BS Traditional	Plan B - Plan of benefits formerly offered through IHA	Plan C - Plan of benefits formerly offered through Univera	Plan D - BC/BS POS Community Blue
<b>Services Without a Referral</b>	Not applicable.	Not applicable.	Not applicable.	Not applicable.
<b>Hospital Room &amp; Board, Services &amp; Supplies</b>	Covered in full - 365 days by basic hospital coverage. Further benefits covered by Major Medical (semi-private room allowance).	Covered in full for unlimited number of days when medically necessary.	Covered in full for unlimited number of days when medically necessary.	Covered in full for an unlimited number of days when medically necessary.
<b>Out-of-Area Hospital Elective Admissions</b>	Covered the same as in-area (all BCBSWNY hospitals accept payment as payment in full).	Covered in full if prior authorization has been obtained. If no prior authorization, payable under OON benefits.	Covered in full if prior authorization has been obtained. If no prior authorization, payable under OON benefits.	Covered in full if prior authorization has been obtained. If no prior authorization, payable under OON benefits.
<b>Skilled Nursing Facility</b>	Unlimited days for skilled level of care by major medical when admitted to a participating facility within 30 days of discharge from a hospital if continued skilled care is medically necessary. Custodial care is not covered.	Covered in full for up to 45 days when admission is authorized by BCBSWNY. Custodial care is not covered.	Covered in full for up to 45 days when admission is authorized by BCBSWNY. Custodial care is not covered.	Covered in full for up to 50 days per member per year when admission is authorized by BCBSWNY.
<b>Home Health Care</b>	Covered in full for up to 365 visits per calendar year from approved agencies in lieu of hospital or Skilled Nursing Facility stay, when ordered by a physician.	\$8 copayment per visit when approved by BCBSWNY.	\$5 copayment per visit when approved by BCBSWNY. No copay for dependents under age 19.	Specialist co-payment per visit.
<b>Doctor's Office Visits and Medical Checkups</b>	Covered by Major Medical.*	\$8 copayment per office visit.	\$5 copayment per office visit. No copay for dependents under age 19.	\$5 PCP/\$10 Spec. Plus Options: \$0/\$15 or \$5/\$10
<b>Routine Physicals</b>	Covered by Major Medical to \$50 per member per calendar year, not subject to deductible or coinsurance.	\$8 copayment per office visit.	\$5 copayment per office visit. No copay for dependents under age 19.	PCP copayment per office visit.

For questions specific to coverage contact: Blue Cross @ 887-8880 or 1-888-299-2263

CATEGORY	Plan A - BC/BS Traditional	Plan B - Plan of benefits formerly offered through IHA	Plan C - Plan of benefits formerly offered through Univera	Plan D - BC/BS POS Community Blue
<b>Eye Care</b>	Medical - covered by Major Medical.* Routine vision examinations are not covered.	Medical - \$8 copayment per office visit. One routine eye exam will be covered once every calendar year, subject to a copayment of \$10. Discounts on eyewear at Eye Med Vision providers.	Covered for a \$5 copayment. Discounts on eyewear at Eye Med Vision providers. No copay for dependents under age 19.	Medical - \$10 copayment per office visit. Routine vision exam once every two years with a \$10 copayment for adults. Annual vision exam for children age 14 and under who have documented refractive error. Discount on eyewear at Eye Med Vision providers.
<b>Prescriptions - Standard in Most Contracts</b>	Dual copayment prescription: \$5 generic, \$10 name-brand. Oral contraceptives are covered. Accepted at all network pharmacies. Contact BCBSWNY for a list of all network pharmacies.	Three-tier prescription coverage: \$5/\$15/\$30 copayment per prescription for up to a 30 day supply when written by a participating physician and filled at a participating pharmacy. Oral contraceptives are covered.	Three-tier prescription coverage: \$5/\$10/\$25 copayment per prescription for up to a 30 day supply when written by a participating physician and filled at a participating pharmacy. Oral contraceptives are covered.	Three-tier prescription coverage: \$5/\$10/\$25 copayment per prescription for up to a 30 day supply when written by a participating physician and filled at a participating pharmacy. Oral contraceptives are covered.
<b>Mental Health Services Inpatient</b>	Hospital stays covered up to 30 days per calendar year. Further days covered in full by Major Medical. NY State operated psychiatric hospital covered for 30 days per member per year. Physicians' fees covered for all covered inpatient days.	Hospital stays covered in full for up to 30 days including 30 physician visits per member per calendar year.	Covered in full for up to 60 days per calendar year; 30 days per admission.	Hospital stays and physician fees are covered in full for 30 days per member per calendar year for acute care.
<b>Mental Health Services Outpatient</b>	Covered in full for 40 visits per member per calendar year.	Covered for up to 20 visits per calendar year. \$8 copayment per visit.	Covered for 20 visits per member per calendar year. \$5 copayment per visit. No copay for dependents under age 19.	20 visits per member per calendar year at the specialist copay

For questions specific to coverage contact: Blue Cross @ 887-8880 or 1-888-299-2263

CATEGORY	Plan A - BC/BS Traditional	Plan B - Plan of benefits formerly offered through IHA	Plan C - Plan of benefits formerly offered through Univera	Plan D - BC/BS POS Community Blue
<b>Chiropractic Services</b>	Covered in full when medically necessary. Participating providers accept payment as payment in full.	\$8 copayment when medically necessary.	\$5 copayment when medically necessary. No copay for dependents under age 19.	\$5 co-payment for unlimited number of visits when medically necessary. No referral necessary.
<b>Podiatrists</b>	Covered for non-routine care. Participating providers accept allowance as payment in full.	Covered with an \$8 member copayment for medically necessary services. Routine foot care is not covered.	Covered with a \$5 member copayment for medically necessary services. Routine foot care is not covered. No copayment for dependents under age 19.	Specialist copayment when medically necessary. Routine foot care is not covered.
<b>Outpatient Rehabilitative Therapy</b>	Covered by Major Medical on doctor's orders for short-term restorative physical therapy. Participating providers accept the allowance as payment in full.	\$15 copayment per visit for short-term restorative physical therapy for up to two consecutive months per diagnosis.	Covered with a \$5 copayment for up to 30 visits per year. No copayment for dependents under age 19.	Specialist co-payment per visit for short-term restorative physical therapy; up to 20 visits covered in a calendar year when authorized by BCBSWNY.
<b>Prosthetic Devices (Artificial Limbs, etc.)</b>	Covered by Major Medical.*	Internal is covered in full. External covered at 50%.	Internal prostheses covered in full. External not covered except for post-mastectomy prosthetics.	Internal prostheses covered in full. External not covered except for post-mastectomy prosthetics.
<b>Durable Medical Equipment</b>	Covered by Major Medical.*	50% coinsurance, up to \$1000 per member per calendar year.	Not covered except for diabetic equipment and supplies.	Durable medical equipment is covered at 20% copayment when arranged for by a BCBSWNY physician and received through a participating provider.
<b>Unmarried Dependent Children</b>	Effective July 1, 2011: Generally, eligible dependents are covered to age 26, unless they have access to insurance through their own employer, even if there is a cost associated.			
<b>Out of Network</b>	Not Applicable	20% coinsurance, \$250/\$500 deductible with an out of pocket max of \$2,000/\$4,000	20% coinsurance, \$200/\$400 deductible with an out of pocket max of \$3,000/\$6,000	20% coinsurance, \$250/\$500 deductible with an out of pocket max of \$2,000/\$4,000



For questions specific to coverage contact: Blue Cross @ 887-8880 or 1-888-299-2263

CATEGORY	Plan A - BC/BS Traditional	Plan B - Plan of benefits formerly offered through IHA	Plan C - Plan of benefits formerly offered through Univera	Plan D - BC/BS POS Community Blue
<p><b>Major Medical</b></p>	<p>*Except where otherwise stated, BCBSWNY has a <b>calendar year deductible of \$150 per individual (\$300 per family)</b>. Where the deductible applies, and when it has been met, Major Medical pays 80% of the Schedule of Allowances until benefits total \$2,000 per individual, (\$4,000 per family) then pays 100% of the Schedule of Allowances for that year. Unlimited lifetime max.</p>	<p>Not applicable.</p>	<p>Not applicable.</p>	<p>Not applicable.</p>

**BUFFALO CITY SCHOOL DISTRICT  
EMPLOYEE HEALTH INSURANCE ENROLLMENT FORM**

**RETURN FORM TO: Buffalo City School District  
Benefits Department Room 806 City Hall  
Buffalo, New York 14202 Telephone: 816-3754**

**NEW ENROLLMENT**

**CHECK ONE:**     **Plan A – BC/BS TRADITIONAL (Indemnity Plan)**     **Plan B – Plan of Benefits formerly offered through INDEPENDENT HEALTH (POS)**  
 **Plan C – Plan of Benefits formerly offered through UNIVERA (POS)**     **Plan D – COMM. BLUE or**     **COMM. BLUE Plus - (CIRCLE co-pay choice: \$5/10 or \$0/15 (PCP/Specialist))**

Applicant's Last Name		First Name	MI	Home Telephone	Alternate Telephone	Social Security Number
Street Address			City		State	Zip Code
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Care Physician – Required (except with Plan A)			Email Address	

**Marital Status:**     **Single**     **Married Date:**    /    /     **Divorced Date:**    /    /     **Widowed Date:**    /    /

Names of Eligible Dependents to be Covered	Date of Birth MM/DD/YY	Social Security #	Relationship	Email address	Primary Care Physician – Required for each member (except with Plan A)
Spouse's Name			<input type="checkbox"/> Husband <input type="checkbox"/> Wife		
Dependent			<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
Dependent			<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
Dependent			<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
Dependent			<input type="checkbox"/> Son <input type="checkbox"/> Daughter		

**Is your spouse employed by or retired from the Buffalo City School District?**     **Yes**     **No**

**Does any individual listed above have additional health coverage, including, but not limited to Medicare?**     **Yes**     **No (Attach a copy of the card.)**

**IMPORTANT – PLEASE READ AND SIGN BELOW**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I authorize any licensed doctor, hospital or other health care provider to provide my plan with any information requested concerning medical services I or members of my family have received, which the plan determines is necessary for the operation and regulation of the plan.

This information will be kept confidential.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**EMPLOYER SECTION – DO NOT COMPLETE**

**Group #:** \_\_\_\_\_ **Sub Group:** \_\_\_\_\_ **Class:** \_\_\_\_\_

**Eligibility Date:** \_\_\_\_\_ **Medicare A Date:** \_\_\_\_\_

**Retirement Date:** \_\_\_\_\_ **Medicare B Date:** \_\_\_\_\_

**Coverage:**     **Single**     **Family**    **Union:** \_\_\_\_\_ **Status:** \_\_\_\_\_

**Group Administrator:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## EMPLOYEE ACKNOWLEDGEMENT

### COBRA

Under the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, temporary group health insurance continuation plan is available to you and covered members of your family should you lose health insurance coverage through the District. COBRA requires employers to offer eligible persons who lose group health plan coverage, the opportunity to continue their group health insurance coverage at their own expense.

I acknowledge receipt of COBRA information and if married, I will discuss this notice with my spouse and other family members. I am aware that the complete COBRA Initial Notice is available on-line at [buffaloschools.org](http://buffaloschools.org).

### HIPAA

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires group health plans to notify you about their policies and practices governing the confidentiality of your medical information. These policies and practices are first effective beginning April 14, 2003. Each Plan’s privacy policy and practices protect confidential medical information that identifies you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable medical information is known under HIPAA as “protected health information” (“PHI”). Your PHI will not be used or disclosed by any Plan without a written authorization from you, except as described in the Plan’s Notice or as otherwise permitted by federal and state medical information privacy laws.

I acknowledge receipt of HIPAA information from the Buffalo Board of Education. If married, I will discuss this notice with my spouse and other family members. I am aware that the complete Plan Notice is available on-line at [buffaloschools.org](http://buffaloschools.org).

### EMPLOYEE RESPONSIBILITY

**I understand that it is my responsibility, as an employee of the Buffalo Board of Education, to notify the Benefits Office within 30 days of any life changing event, such as divorce, death or the aging off of dependent children. I further understand that failure to do so, could result in unwarranted premium payments or submission of claims for ineligible dependents. In the case of events, such as marriage, birth and adoption, failure to report within 30 days will result in a delayed effective date of the additional coverage.**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# BUFFALO BOARD OF EDUCATION

Payroll Department  
814 City Hall  
Buffalo, NY 14202

**Dr. James Williams**  
Superintendent of Schools

## Direct Deposit Enrollment / Change Form

To enroll in Direct Deposit, simply fill out **PART ONE** of this form and return it to the Board of Education Payroll Department. **Attach a voided check for each checking account**, not a deposit slip. If depositing to a savings account, ask your bank to give you the Routing/Transit Number for your account. It isn't always the same as the number on a savings deposit slip. This will help ensure that you are paid correctly.

All accounts with the Buffalo Metropolitan Federal Credit Union have to be set up with them and they will forward the paperwork to us. No changes need to be made if you currently have deductions sent to the Federal Credit Union, and those deductions will not be changed. **Are you a member of the Credit Union** YES \_\_\_\_\_ NO \_\_\_\_\_

**Important! Please read and sign before completing and submitting.**

I hereby authorize the Buffalo Board of Education (hereinafter "BOE") to deposit any amounts owed me by initiating the credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by the BOE to my account. In the event that the BOE deposits funds erroneously into my account, I authorize The BOE to debit my account for an amount not to exceed the original amount of the erroneous credit.

I agree that this authorization will remain in full force and effect until the BOE and the Bank have received written notice from me of any modification. Any modification will require 3-4 weeks to complete.

Date: _____	Employee #: _____	Dept. _____	Location _____
Employee Name: _____		Employee # _____	
<b>(Please Print Name)</b>			
Employee Signature: _____			

**(PART 1 )**

### NEW ACCOUNT INFORMATION

**(PART 1)**

The last item must be for the remaining amount owed to you. To distribute to more accounts, please complete another form. Make sure to indicate what kind of account, along with amount to be deposited, if less than your total net paycheck (**NO CHECK WILL BE ISSUED TO YOU**). If a negative check is created due to excessive deductions the Payroll Department reserves the right to make the necessary adjustments.

1. Bank Name/City/State: _____			
Routing/Transit #: _____		Account #: _____	
Checking	Savings	Other	I wish to deposit: \$ _____ or Entire Net Amount

2. Bank Name/City/State: _____			
Routing/Transit #: _____		Account #: _____	
Checking	Savings	Other	I wish to deposit: \$ _____ or Entire Net Amount

3. Bank Name/City/State: _____			
Routing/Transit #: _____		Account #: _____	
Checking	Savings	Other	I wish to deposit: \$ _____ or Entire Net Amount

**Participating Service Providers Contact List  
Buffalo City School District**

403(b) Tax Shelter Annuity Providers	
AIG Valic 8465 Springbrook Ct East Amherst NY 14051 625-6066	ING Life Insurance & Annuity Company 6225 Sheridan Drive, Suite 212 Williamsville NY 14221 626-3920
AXA Equitable Life Insurance Company 105 Roosevelt Avenue Buffalo NY 14215 832-4828 or 626-2500	Mass Mutual Annuity Center 147 Linwood Ave Buffalo NY 14209 881-2277
Citistreet (Metlife Resources) 6265 Sheridan Dr, Suite 200 Williamsville NY 14221 626-0048	Mass Mutual VA 6195 West Quaker Road Orchard Park NY 14127 662-0070
Fidelity Management Trust Company 201 South Main #200 Salt Lake City Utah 84111 1-800-343-0860	Metlife Insurance Company 150 Essjay Road, Suite 102 A Williamsville NY 14221 634-1515
First Investors Corporation 2430 North Forest Road, Suite 130 Getzville NY 14068 636-9535	NY Life Insurance and Annuity 6400 Main St, Suite 110 Williamsville NY 14221 631-2323
FTJ/L&M Financial 3820 Sheridan Drive Amherst NY 14226-1723 839-1234	Sgrio Financial LLC 965 Union Road West Seneca NY 14224 674-6700
GWN 8070 Floss Lane Amherst NY 14051 741-3163	The Legend Group 450 Corporate Parkway, Suite 102 Amherst NY 14226-1256 837-3335

457 NYS Deferred Compensation
<p><a href="http://www.nysdcp.com">www.nysdcp.com</a> or call 800-422-8463</p>

All Buffalo City School District employees are eligible to have a payroll deduction for a 403(b) Tax Shelter Annuity and/or a 457 Deferred Compensation Plan.

## Employee Assistance Program (EAP)

The Buffalo City School District has contracted with Employee Resources to provide an Employee Assistance Program for you. EAP is an assessment/referral service provided to help you and your family members when you have problems which may be interfering with your everyday functioning. We all have problems and we usually handle them, but occasionally we need help. Employee Resources has several EAP offices with day and evening hours for your convenience.

What types of issues does EAP address?

Stress ♦ Anxiety ♦ Parent/Child ♦ Sexual Abuse ♦ Grief ♦ Anger ♦ Job ♦ Legal  
Divorce ♦ Marital ♦ Financial ♦ Depression ♦ Alcohol/Drug Abuse ♦ Wellness

Telephone: (716)854-1990

Website: [employeeresources.com](http://employeeresources.com)

E-mail: [eap@employeeresources.com](mailto:eap@employeeresources.com)

**EAP** **EMPLOYEE RESOURCES, INC.**  
EMPLOYEE ASSISTANCE PROGRAM

Employee | Employer

**What's New?**

Our new **EAP Online Newsletter** is here! It is a Quarterly Newsletter, with new articles for you at the beginning of each of our beautiful four seasons.

Welcome to all of the employees of

Our **Number 1** Priority!

- Employers offer many benefits to valued employees, and you are fortunate if an **EMPLOYEE ASSISTANCE PROGRAM** is one of them.
- A positive mental state in the workplace is your key to success. If you need assistance keeping yourself balanced in these hectic times, we can help!
- For employees, it is *Confidential, Easy to Access*, and best of all it's *Free!*
- Getting started is simple. You may want to browse through our website or just [click here](#) to make an appointment or give us a call. Start getting help today!

Phone: (716) 854-1990 • 467 Virginia Street • Buffalo, New York 14202  
Fax: (716) 855-2456

[Home](#) - [Our Services](#) - [FAQ's](#) - [The EAP Process](#) - [Information Request](#) - [Links](#) - [Contact Info](#)  
[Company Profile](#) - [Message from CEO](#) - [Why An EAP?](#) - [News](#) - [Employer FAQ's](#) - [Trainings](#)

# Wellness Resource Courtesy of Blue Cross/Blue Shield

**Website: [www.bcbswny.com](http://www.bcbswny.com)**



**BlueCross BlueShield of Western New York**

[Plans & Benefits](#) | [I'm a Member](#) | [I'm an Employer](#) | [I'm a Broker](#) | [I'm a Provider](#)


## My Health



[Find a Doctor](#)

[Find a Lab](#)

[Get Health](#)

- > [Pharmacy Services](#)
- > [Speak Up for Yourself](#)
- > [Patient Safety Solutions](#)
- > [2008 Health Care Quality Improvement Overview](#)
- > [Summary of Collaborative and Coalition Activities](#)
- > [How Do We Reimburse Our Providers?](#)
- > [Multicultural Health Information Resource](#)
- > [You&Blue](#) 

## Health Resources

- > [BlueLife Health Education and Wellness Program](#)
- > [Health Library A-Z \(Healthwise\)](#)
- > [Discount Services](#)
- > [Toll Free Services](#)
- > [Related Links](#)

Learn How *WalkingWorks*™



You don't need a lot of time to be more active. Even small choices you make today add up to better health tomorrow.

## Featured Topics of the Month

- [Calorie Burner Calculator](#)
- [Fitness](#)

### Upcoming Topics

- [Planning for a healthy pregnancy](#)

### What is Hot!!

- > [Tips to Help Your Teen Quit Tobacco](#)
- > [Improve Your Health](#)
- > [Health Care Quality Improvement Department Telephone Intervention Center Information](#)
- > [Member Wellness Checklist](#)
- > [BlueLife Tobacco Treatment Program Available](#)
- > [BlueLife Registered Dietitian Counseling Program Available](#)

## Get Started

- > [Arthritis](#)
- > [Asthma](#)
- > [Back care](#)
- > [Case Management Services](#)
- > [Diabetes](#)
- > [Family Health](#)
- > [Healthy Body](#)
- > [Heart Health](#)
- > [HIV AIDS/STDS](#)
- > [Holistic Health](#)
- > [Mental Health](#)
- > [Physical Activity and Fitness](#)
- > [Preventive Health](#)
- > [Right Start Pregnancy](#)
- > [Safety](#)
- > [Senior Health](#)
- > [Smoking Cessation](#)
- > [Stress Management](#)
- > [Women's Health](#)