STATE OF NEW YORK
DEPARTMENT OF CIVIL SERVICE
THE STATE CAMPUS
ALBANY, NEW YORK 12239

EMPLOYEE BENEFITS DIVISION

NYS HEALTH INSURANCE TRANSACTION FORM

PS-404 (7/00L) (w) Page/Side1

INSTRUCTIONS: READ BOTH SIDES. FILL IN (PLEASE PRINT), CHECK, OR INITIAL THE APPROPRIATE CHOICES

EMPLOYEE INFORMATION *(All employees must complete)*

1. Last Name First Name Middle Initial
2. Social Security Number
3. Sex ☐ M ☐ F
4. Street Address
   City State ZIP
5. Marital Status
   ☐ Single ☐ Widowed
   ☐ Married ☐ Divorced
   ☐ Separated
   Marital Status Date: Mo. Day Year
6. Date of Birth: Month Day Year
7. Work Location and Address
8. Telephone Number
   Home ( ) ____ ☐
   Work ( ) ____ ☐
   Days

NEW ENROLLMENT INFORMATION

9. Select Coverage
   ☐ Individual
   ☐ Family
10. Select Benefit Plan
    ☐ Empire Plan
    ☐ HMO ______________ *(Specify Name)*
    (A completed HMO Enrollment Form Must be Attached)
    HMO Code ☐☐☐
11. Covered under Medicare?
    Self ☐ Yes ☐ No
    Spouse/ Domestic Partner ☐ Yes ☐ No

PREVIOUS COVERAGE INFORMATION

12. If you were previously covered under NYSHIP or another health insurance plan (attach proof i.e. insurance bill or letter stating former coverage), please complete these details. ⟶

Previous ID Number ______________

Date Coverage Terminated: Mo. Day Year

Enrollee's Name Under Which Previously Covered: Last First MI

DEPENDENT INFORMATION

13. **Date of Event** ______________________

Use Additional Sheets if Necessary

CHECK: A (ADD), D (DELETE), OR C (CHANGE)	Name Last	First	MI	RELATION-SHIP	DATE OF BIRTH	SEX	ADDRESS (if different)	SOCIAL SECURITY NO.
☐ A ☐ D ☐ C					Mo. Day Year			
☐ A ☐ D ☐ C					Mo. Day Year			
☐ A ☐ D ☐ C					Mo. Day Year			
☐ A ☐ D ☐ C					Mo. Day Year			

REQUEST FOR EMPIRE PLAN CARD ONLY

A name change automatically generates a new New York State Government Employee Benefit Card. It is not necessary to request one. For Health Maintenance Organization (HMO) cards, contact your HMO.

☐ DUPLICATE CARD
(Previously issued card remains valid.)

☐ REPLACEMENT CARD
(Previously issued card(s), lost or stolen, become invalid.)

FOR

☐ ENROLLEE
☐ ENROLLEE AND ALL DEPENDENTS
☐ INDIVIDUAL DEPENDENT
Name ______________________

BENEFIT PLAN CHANGE

(See NYSHIP General Information Book for Guidelines.)

14. Change Benefit Plan to ☐ Empire Plan ☐ HMO ____________________ (Specify Name) HMO Code ☐☐☐

(A completed HMO Enrollment Form Must be Attached.)

COVERAGE CHANGE

(Complete this section for a change in enrollment status. Appropriate documentation is required.)

15. Change to **FAMILY** Coverage *Check Reason*

Date of Event: Mo. | Day | Year

- ☐ Marriage
- ☐ Domestic Partner
- ☐ First dependent child acquired
- ☐ Dependent returned to full- time student status
- ☐ Request coverage for dependents not previously covered
- ☐ Newborn
- ☐ Previous coverage terminated **(Complete Box #12)**
- ☐ Other ____________________

16. Change to **INDIVIDUAL** Coverage *Check Reason*

Date of Event: Mo. | Day | Year

- ☐ I voluntarily cancel coverage for my dependents
- ☐ I voluntarily cancel coverage for my domestic partner
- ☐ Only dependent died
- ☐ Only dependent married
- ☐ Only dependent graduated
- ☐ Only dependent disqualified by age
- ☐ Divorce
- ☐ Termination of domestic partnership **(Completed PS-425.4 attached)**
- ☐ Other ____________________

AUTHORIZATION

(Initial the box of the appropriate statement, then sign and date below.)

a) ☐ I **request enrollment** in the New York State Health Insurance Program. I have read the Pre-Tax Contribution Program memorandum, and ☐ I choose to participate. ☐ I choose NOT to participate.

b) ☐ I **voluntarily decline** to enroll in the New York State Health Insurance Program. I understand I may subject myself and/or my eligible dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving State service (vest, retirement, etc.).

c) ☐ **I wish to voluntarily cancel** my health insurance coverage. I understand I may subject myself and/or my eligible dependents to waiting periods if I decide to enroll at a later date and I may be forfeiting the right to such coverage after leaving state service. (CAN/VOL)

d) LEAVE WITHOUT PAY:
☐ **I wish to continue** health insurance while on authorized leave without pay.
☐ **I do not wish to continue** health insurance coverage while I am on authorized leave without pay and I wish to resume my coverage upon return to the payroll. (CAN/LOA)

e) RETIREE:
☐ **I understand** the requirements for continuing health insurance coverage as a retiree and wish to continue my coverage.
☐ **I understand** the requirements for continuing health insurance coverage as a retiree and wish to defer my coverage (A completed PS-406.2 must be attached.)

I CERTIFY THAT THE INFORMATION I HAVE SUPPLIED IS TRUE AND CORRECT. I understand that my failure to provide required proof(s) within 28 days (30 days for newborns) may delay the availability of benefits for me or any dependent for whom I fail to provide such proof.

Any person who makes a misstatement of fact or conceals any pertinent information, commits a crime which is subject to a $5,000 penalty *and* the stated value of the claim for *each* violation.

I hereby ***authorize deduction from my salary or retirement allowance*** of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

Enrollee's Signature (Required) ______________________________ Signature Date (Required) __________

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

This information is being requested pursuant to Section 163 of the New York State Civil Service Law for the purpose of enabling the Department of Civil Service to enroll the employee in a health insurance program or to make changes in such enrollment/coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide this information may result in denial of benefits. While this information will be maintained by your Personnel Office, the Director of the Employee Benefits Division, Department of Civil Service, The State Campus, Albany, NY 12239 is responsible for these records and information contained therein may not be released without the Director's authorization. For further information relating *only* to the Personal Privacy Protection Law, call (518) 457-9375. All other questions should be directed to your Personnel Office.

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	Full/Less than 50% time	Agency Code	Line Item #	Neg. Unit	Ret. Sys.

Ret. Tier	Registration #	Sick Leave Information: # Hours	$ _____ . ____ Hourly Rate of Pay	Date Entered on NYBEAS	Effective Date

HBA Signature	Date