NEW YORK STATE OF OPPORTUNITY. **Department of Civil Service**

EMPLOYEE BENEFITS DIVISION
Health Insurance Transaction Form for NYS Employees

PS-404 (5/20)

INSTRUCTIONS: READ AND COMPLETE BOTH SIDES/PAGES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.

EMPLOYEE INFORMATION *(All employees must complete)*

1. Last Name | First Name | MI

2. Social Security Number

3. Sex ☐ Male ☐ Female

4. Permanent Address Street | City | State | Zip

5. Mailing Address (If different) Street | City | State | Zip

6. Work Location & Address Street | City | State | Zip

7. Date of Birth

8. Telephone Numbers Primary ( ) Work ( )

9. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated | Marital Status Date

10. Covered under Medicare? Self: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No Child: ☐ Yes ☐ No

11. ELECT OR DECLINE COVERAGE

A. Choose a Pre-Tax election

1. ☐ **Elect Pre-Tax Status** for Premium deduction **2.** ☐ **Elect After-Tax Status** for Premium deduction
You are only eligible for Pre-Tax deductions if newly eligible or if requested during the Pre-Tax Contribution Program (PTCP) Election Period

B. Select a NYSHIP Coverage Option (Choose option 1, 2, 3 or 4)

1. Individual Enrollment	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	☐ Dental *(11)*
2. Family Enrollment *(Complete box 13 on page 2)*	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	☐ Dental *(11)*
3. Decline Coverage	☐ Medical *(10)* ☐ Dental *(11)*	

12. CHANGE OR CANCEL EXISTING COVERAGE

A. Change Coverage: ☐ Medical *(10)* ☐ Dental *(11)* **Date of Event:** _____

☐ **Change to FAMILY** *(Complete box 13)*

- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Dependent returned to full-time student status
- ☐ Other: _____

☐ **Change to INDIVIDUAL**

- ☐ Divorce
- ☐ Termination of Domestic Partnership *(Attach completed PS-425.4)*
- ☐ Only dependent ineligible due to age
- ☐ I voluntarily cancel coverage for my dependents
- ☐ Only dependent died
- ☐ Only dependent married
- ☐ Only dependent graduated
- ☐ Other: _____

NOTE: If you are indicating a change in marital status to Divorced or Separated, please be sure to update the address information for the dependent in Box 13 if applicable.

B. Voluntarily Cancel Coverage: ☐ Medical *(10)* ☐ Dental *(11)* Qualifying Event: _____

NOTE: If you are enrolled in the PTCP, you may make changes during the Annual Option Transfer Period or when experiencing a PTCP qualifying event.

13. DEPENDENT INFORMATION

Must be provided when choosing to enroll in NYSHIP family coverage *(use additional sheets if necessary)*

Check One: A (Add), D (Delete) or C (Change)
Check all that apply: M (Medical), D (Dental)

Date of Event: _____

Check		Last Name First Name MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security Number
☐ A ☐ D ☐ C	☐ M ☐ D						
☐ A ☐ D ☐ C	☐ M ☐ D						
☐ A ☐ D ☐ C	☐ M ☐ D						
☐ A ☐ D ☐ C	☐ M ☐ D						

14. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW

Change NYSHIP Option	Change to: ☐ Empire Plan ☐ HMO Code ☐	HMO Name: _____
Change Pre-Tax Status	Change to: ☐ Pre-Tax ☐ After-Tax	Submit during the Pre-Tax Contribution Program Election Period

Personal Privacy Protection Law Notification

The information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance 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 the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

AUTHORIZATION

I have read the Pre-Tax Contribution Program materials and the Opt-out Attestation Form (if applicable) and have made my selection on Page 1 of this document. I understand that if my coverage is declined or canceled, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date and may forfeit the right to such coverage after leaving State service (vest, retirement, etc.). I am aware of how to obtain a current *Summary of Benefits and Coverage* for the NYSHIP option I have selected. I understand that my failure to provide required proof(s) within 30 days may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims.
I certify that the information I have supplied is true and correct. I hereby authorize deduction from my salary or retirement allowance of the amount required, if any, for the coverage indicated above.

Employee Signature (Required): _____ **Date:** _____

AGENCY USE ONLY

Retirement Tier	Registration #	Sick Leave Information # Hours	Sick Leave Information Hourly Rate of Pay	Date Entered on NYBEAS	Effective Date

HBA Signature (Required): **Date:**