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

EMPLOYEE BENEFITS DIVISION
HEALTH INSURANCE TRANSACTION FORM
FOR NYS & PE EMPLOYEES PS-404 (9/17)

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

EMPLOYEE INFORMATION *(All employees must complete)*

1. Last Name: Smith	First Name: Jane	MI	2. Social Security Number: 123-45-6789
3. Sex: ☐ Male ☑ Female			
4. Permanent Address Street: 123 Forth Street	City: New York	State: NY	Zip: 10000
5. Mailing Address (If different) Street:	City:	State:	Zip:
6. Work Location & Address Street: CUNY Graduate Center 365 Fifth Ave	City: New York	State: NY	Zip: 10016
7. Date of Birth: 1/10/1980	8. Telephone Numbers Primary: (987) 654-3210	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 (Only eligible for Pre-Tax deductions if newly eligible or if requested during the PTCP election period, Nov 1-30)

1. ☑ **Elect Pre-Tax Status** for Premium deduction 2. ☐ **Elect After-Tax Status** for Premium deduction

B. Select a NYSHIP Coverage Option (Choose option 1, 2, 3 or 4) (NOTE: HMO and Opt-out not available to CUNY)

1. Individual Enrollment	Medical *(10)* *(Select Empire Plan or HMO)* ☑ Empire Plan ☐ HMO Code ☐ Name _____	☐ Dental *(11)*	☐ Vision *(14)*
2. Family Enrollment *(Complete box 13 on page 2)*	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	☐ Dental *(11)*	☐ Vision *(14)*
3. Opt-out Program *(NYS Medical only)*	☐ Individual Opt-out ☐ Family Opt-out (Complete Box 13) If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.	☐ Dental *(11)*	☐ Vision *(14)*
4. Decline Coverage	☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)*		

12. CHANGE OR CANCEL EXISTING COVERAGE

A. Change Coverage: ☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* **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 *(Dental and Vision only)*
- ☐ 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 *(Dental and Vision only)*
- ☐ Only dependent graduated *(Dental and Vision only)*
- ☐ 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)* ☐ Vision *(14)* Qualifying Event: _____

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

13. DEPENDENT INFORMATION

Must be provided when choosing to enroll or opt-out of 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), and V (Vision)
Date of Event: _____

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

14. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW

Change NYSHIP Option	Change to: ☐ Empire Plan ☐ HMO Code ☐ HMO Name: _____	
Elect Opt-out *(NYS Medical only)*	☐ Individual Opt-out ☐ Family Opt-out	If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.
Change Pre-Tax Status	Change to: ☐ Pre-Tax ☐ After-Tax	Submit during the Pre-Tax Contribution Selection Period (November 1-30)

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 of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 473-2624. For information related to the Health Insurance Program, **contact your Health Benefits Administrator**. If, after calling your Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 4:00 p.m. Eastern time.

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): Jane Smith **Date:** 01/02/2020

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:**