State of New York Department of Civil Service Albany, NY 12239	EMPLOYEE BENEFITS DIVISION NYS HEALTH INSURANCE TRANSACTION FORM PS-404 (12/12)

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. Street Address City State Zip			
5. Date of Birth	**6.** Telephone Numbers Home ( ) Work ( )		**7.** Work location and address
8. Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated	Marital Status Date		
9. Covered under Medicare? Self ☐Yes ☐ No Spouse/Domestic Partner ☐Yes ☐ No Child ☐Yes ☐ No			

10. ENTER REQUEST(S) BELOW

A. ☐ Request Enrollment- **Individual**	Medical *(10)* *(Select Empire Plan, HMO or opt out)* ☐Empire Plan ☐ HMO Code ☐ Name _____ ☐OPT OUT If choosing opt out, you must also complete the PS409 Opt-out Attestation Form	☐ Dental *(11)*	☐ Vision *(14)*
B. ☐ Request Enrollment- **Family** (Complete G)	Medical *(10)* *(Select Empire Plan or HMO)* ☐Empire Plan ☐ HMO Code ☐ Name _____ ☐ OPT OUT If choosing opt out, you must also complete the PS409 Opt-out Attestation Form	☐ Dental *(11)*	☐ Vision *(14)*
C. ☐ Elect Pre-Tax Status for Premium deduction?	D. ☐ Elect Post-Tax Status for Premium deduction?	Initial here to indicate that you have read the Pre-Tax Contribution memorandum. _____	
E. ☐ Decline Coverage	☐Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* *(Process WAV/BEN transaction)*		
F. ☐ Voluntarily Cancel Coverage	☐Medical *(10)* Qualifying Event:	☐ Dental *(11)*	☐ Vision *(14)*

G. ☐ Change Coverage ☐Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* **Date of Event: _____**

☐ **Change to FAMILY** *(Complete G)*

- ☐ 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 Section 11)*
- ☐ Other _____

☐ **Change to INDIVIDUAL**

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

DEPENDENT INFORMATION

Must be provided when choosing to enroll or opt-out of NYSHIP coverage *(use additional sheets if necessary)*

Check One: A (Add), D (Delete) or C (Change) **Date of Event** _____

Check all that apply: M (Medical), D (Dental), and V (Vision)

	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						
☐ A ☐ D ☐ C ☐ M ☐ D ☐ V						

10. *Continued*. **ENTER REQUEST(S) BELOW**

H. ☐ Change NYSHIP Option — Change to: ☐ Empire Plan ☐ HMO Code ____ HMO Name _____ Opt-Out ☐

I. Change Pre-Tax Status — Change to: ☐ Pre-Tax ☐ Post-Tax — Processed only by the Employee Benefits Division during the Pre-Tax Contribution Selection Period (November)

11. PREVIOUS COVERAGE INFORMATION

If you were previously enrolled in a NYSHIP plan, or were covered another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.

Previous ID Number	Date the other coverage terminated
Enrollee's Name Under Which Previously Covered — Last / First / Middle Initial	

12. LEAVE WITHOUT PAY AND RETIREMENT STATUS

LEAVE WITHOUT PAY

☐ I wish to continue coverage while I am on authorized leave. I understand that I will be billed for this coverage. ☐ Medical ☐ Dental ☐ Vision

☐ I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll. ☐ Medical ☐ Dental ☐ Vision

RETIREMENT

☐ I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage.

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

13. REQUEST FOR EMPIRE PLAN CARD ONLY

For Health Maintenance Organization (HMO) cards, contact your HMO.

☐ DUPLICATE CARD
(Previously issued card remains valid.)

FOR
☐ ENROLLEE
☐ ENROLLEE AND ALL DEPENDENTS
☐ INDIVIDUAL DEPENDENT
Name _____

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) 457-9375. For information related to the Health Insurance Program, **contact your Agency Health Benefits Administrator**. If, after calling your Agency 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 3:00 p.m.

AUTHORIZATION

I have read the Pre-Tax Contribution Program memorandum and have made my selection on Page 1 of this document, if applicable. I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my 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.). I am aware of how to obtain a current *Summary of Benefits and Coverage* for the NYSHIP option I have selected. **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 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 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.

→ Employee's Signature **(Required)** _____ Signature Date **(Required)** _____

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	Date of 1st Eligibility (PE only)	Percentage Working	Agency Code	Neg. Unit	Ret. System

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

HBA Signature: **Date:**

State of New York Department of Civil Service Albany, NY 12239	EMPLOYEE BENEFITS DIVISION 2014 OPT OUT ATTESTATION FORM PS 409 (11/13)

EMPLOYEE INFORMATION

Name	Social Security Number	Negotiating Unit	
Street Address	City	State	Zip

Date of Birth _____/_____/_____	Telephone Numbers Home ( ) Work ( )		Agency Name and Address
Marital Status ☐ Single	☐ Married ☐ Widowed	☐ Divorced ☐ Separated	Marital Status Date

NYSHIP HEALTH BENEFITS OPT-OUT ELECTION

Complete this section if you are newly eligible or currently enrolled in NYSHIP.

Employees must attest below that they are covered under other employer-sponsored group health insurance coverage other than the State of New York as of the opt out effective date, to be eligible for the Opt-out Program (CSEA employees, see your HBA for additional eligibility information).

Check one:

☐ I am electing to opt out of Individual coverage in exchange for a $1,000 taxable amount.

☐ I am electing to opt out of Family coverage in exchange for a $3,000 taxable amount (dependent information must be provided when electing Family opt-out).

Other employer-sponsored group health insurance information (must be provided)

Name of covered employee_____ Covered employee's Date of Birth_____

Covered employee's SSN_____ Name of covered employee's employer_____

Effective date of alternate health insurance coverage_____

Name and Address of alternate health insurance coverage _____
_____

ATTESTATION

All employees complete this section

I have read the Opt-out Program materials and instructions and I attest to the following:

- I am covered under another employer-sponsored group health plan other than the State of New York that is in effect as of the opt out effective date and have provided my alternate plan information.
- I understand that I must promptly report changes to information I have provided above which may impact my eligibility.
- I understand that I may choose to opt out of Family coverage *only* if I have NYSHIP eligible dependents.
- I understand that this election is for 2014 only.
- I meet the qualifications to elect the Health Insurance Opt-out Program.

Employee's Signature **(Required)** _____ Signature Date **(Required)** ___/____/_____

Employees who can demonstrate and attest to having other employer-sponsored group health insurance may elect to opt out of NYSHIP's Empire Plan or Health Maintenance Organizations. Employees who elect to opt out of NYSHIP will receive $1,000 for waiving Individual coverage or $3,000 for waiving Family coverage. This amount will be credited to bi-weekly paychecks as taxable income over the plan year. Unless newly eligible to enroll, employees must be enrolled in NYSHIP Individual or Family coverage prior to April 1st of the previous plan year to be eligible to opt out of that coverage. This enrollment cannot have been subject to late enrollment. In order to participate, employees must have other employer-sponsored group health insurance.

There are two circumstances when employees may elect to opt out of coverage; as newly eligible for the Opt-out Program, and, for currently enrolled employees, during the Annual Option Transfer Period. Only employees who experience a qualifying event will be allowed to withdraw their Opt-out election and enroll in a health insurance plan mid-year. See instructions below.

INSTRUCTIONS:

Newly eligible employees: Employees may enroll in the Opt-out Program no later than their first date of NYSHIP eligibility. Employees must sign the PS-409 Opt-out Attestation Form and complete a PS-404 Enrollment Form.

Current enrollees: Eligible enrollees may elect the Opt-out Program during the Annual Option Transfer Period for each plan year. Employees must sign the PS-409 Opt-out Attestation Form and complete a PS-404 Enrollment Form.

During mid-year: Employees who experience a Qualifying Event (QE) must notify their personnel office within thirty (30) days of the QE date in order to enroll in a health insurance plan without a waiting period. Employees must complete a PS404 Enrollment Form.

By signing the Opt-out Attestation, you elect to receive $3,000 (Family coverage waived), or $1,000 (Individual coverage waived); this amount will be credited to your bi-weekly paycheck as taxable income over the plan year.

The information you provide on this application is requested in accordance with Section 163 of 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) 457-9375. For information related to the Health Insurance Program, **contact your Agency Health Benefits Administrator**. If, after calling your Agency 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.

This form is invalid if it is not signed and submitted along with a completed PS 404.