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

EMPLOYEE BENEFITS DIVISION

STATEMENT OF DEPENDENCE FOR PARTICIPATION IN THE HEALTH INSURANCE PROGRAM

INSTRUCTIONS: This form must be completed when an enrollee applies for coverage on behalf of a dependent child who is other than the enrollee's own child, adopted or dependent stepchild. For such a dependent to be eligible, the child must, among other things, (1) reside permanently in the enrollee's home and (2) receive more than 50 percent of support from the enrollee, including medical expenses. If you have a dependent who meets these criteria, please complete this form and submit proof of support.

Please read carefully, respond accurately and initial your response to each of the following questions. If you have questions, contact your agency Health Benefits Administrator.

Part A– ENROLLEE'S STATEMENT

Enrollee's Name	Health Insurance Identification Number
Enrollee's Address No. and Street City State Zip Code	
Enrollee's Agency (if on the payroll)	Telephone Work ( ) Home ( )
Dependent's Name	Dependent's Birth Date

1 . What relationship is the dependent to you? _____

2 . Who has legal custody of this dependent? _____

3. Check one: Acting in place of the parent ("*in loco parentis*") for this dependent, I ☐ have ☐ have not assumed responsibility for medical expenses for the above named dependent until the child is age 19 or is otherwise no longer eligible for enrollment in the New York State Health Insurance Program.

4. What percent of the dependent's support do you provide?_____

Please supply documentation of this support: for example, papers indicating legal guardianship or a copy of your Federal tax return listing the individual as a dependent. If you do not claim the dependent on a tax return, we will accept a letter from a CPA or an attorney that the dependent could be claimed on your tax return under current IRS regulations if you chose to do so.

5. Is your home the permanent legal residence of this dependent? ☐ Yes ☐ No

Explain_____

6. How long do you anticipate such legal residence will continue?_____

Be specific; duration of residence if categorized as "indefinite" or "unknown" is not qualifying.

The State may request such proof of support and/or residency that may be satisfactory to it.

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PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

The information you provide on this application is being requested in accordance with Article 11 of the Civil Service law for the principal purpose of enabling the Department of Civil Service to enroll a dependent child the New York State health Insurance program. (NYSHIP) 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 result in the disapproval of your application. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, The State Campus, Albany, NY 12239. For further information relating ***only*** to the Personal Privacy Protection Law call (518) 457-9375. If your have a question, regarding this form or the health insurance coverage please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

This information must be true and accurate, pursuant to the following:

Section 1035 of Title 18 of the United States Code:

(a) Whoever, in any matter involving a health care benefit program, knowingly and willfully - (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or (2) makes any materially false, fictitious, or fraudulent statement or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

Section 86.4 of title 11 of the New York Compilation of Rules and Regulations:

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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Section 176.05 of the Penal Law:

A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, self insurer, or purported insurer, or purported self insurer, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of a commercial insurance policy, or certificate or evidence of self insurance for commercial insurance or commercial self insurance, or a claim for payment or other benefit pursuant to an insurance policy or self insurance program for commercial or personal insurance which he knows to: (i) contain materially false information concerning any fact material thereto; or (ii) conceal, for the purpose of misleading, information concerning any fact material thereto.

Date	Enrollee's Signature

Sworn to before me this

Day of _____, _____.

_____
Notary Public

Part B–FOR OFFICE USE ONLY

☐ Approved

☐ Disapproved

Date Transaction submitted to add Dependent (if necessary)_____

Date	Signature of Health Benefit Administrator

THIS FORM MUST BE RETAINED BY THE EMPLOYING AGENCY WITH THE ENROLLEE'S ENROLLMENT RECORDS.