State of New York
Department of Civil Service
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION
NYS HEALTH INSURANCE TRANSACTION FORM

PS-404 (12/11)

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 ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ 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)
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						
☐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 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:**