



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 Primary Work 7. Work location and address
8. Marital Status Married Divorced Marital Status Date Single Widowed Separated
9. Covered under Medicare? Self: Yes No Spouse/Domestic Partner: Yes No Child: Yes No

10. 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) Date of Event
Check all that apply: M (Medical), D (Dental), and V (Vision)
Table with columns: Last Name, First Name, MI, Relationship, Date of Birth, Sex, Address, Social Security Number

11. NEW OR NEWLY ELIGIBLE EMPLOYEES: CHOOSE ONE OF THE FOLLOWING OPTIONS (A, B OR C)

A. Enroll in NYSHIP Coverage: Choose options 1 or 2 and complete box 3
1. Individual Enrollment Medical (10) (Select Empire Plan or HMO) Dental (11) Vision (14)
2. Family Enrollment (Complete box 10) Medical (10) (Select Empire Plan or HMO) Dental (11) Vision (14)
3. Elect Pre-Tax Status for Premium deduction Elect Post-Tax Status for Premium deduction

B. Elect the Opt-out program (if eligible): Complete boxes 1 and 2

1. Individual Opt-out Family Opt-out If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.
2. Elect Pre-Tax Status for Premium deduction Elect Post-Tax Status for Premium deduction

C. Decline NYSHIP Coverage Medical (10) Dental (11) Vision (14)

12. TO CHANGE OR CANCEL COVERAGE CHOOSE FROM THE BOXES BELOW

A. Change Coverage: Medical (10) Dental (11) Vision (14) Date of Event:
Change to FAMILY (Complete box 10) Change to INDIVIDUAL
Marriage Divorce
Domestic Partner Termination of Domestic Partnership (Attach completed PS-425.4)
Newborn Only dependent ineligible due to age
Request coverage for dependents not previously covered I voluntarily cancel coverage for my dependents
Previous coverage terminated (proof required) Only dependent died
Dependent returned to full-time student status (Dental and Vision only) Only dependent married (Dental and Vision only)
Other Only dependent graduated (Dental and Vision only)
Other

B. Voluntarily Cancel Coverage: Medical (10) Dental (11) Vision (14) Qualifying Event:
NOTE: If you are enrolled in the Pre-Tax Contribution Program, your ability to make mid-year changes may be limited.

13. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW

Change NYSHIP Option	Change to: <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code <input type="text"/> HMO Name _____
Elect Opt-out (if eligible)	<input type="checkbox"/> Individual Opt-out <input type="checkbox"/> Family Opt-out If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.
Change Pre-Tax Status	Change to: <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax Submit during the Pre-Tax Contribution Selection Period (November 1-30)

14. LEAVE WITHOUT PAY AND RETIREMENT STATUS

LEAVE WITHOUT PAY	<input type="checkbox"/> I wish to continue coverage while I am on authorized leave. I understand that I will be billed and must pay for this coverage.	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
	<input type="checkbox"/> I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll.	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
RETIREMENT	<input type="checkbox"/> I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage.	
	<input type="checkbox"/> 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.)	
	<input type="checkbox"/> I understand that I will receive an application for COBRA continuation of Dental and/or Vision coverage automatically.	

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.

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/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	Date of 1 st Eligibility	Percentage Working	Agency Code	Neg. Unit	Retirement System

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

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