## Model Letter for Contacting the Employee Benefits Division

Mail to: State of New York Department of Civil Service
Employee Benefits Division, Albany, New York 12239

(Please print) Date _____

Enrollee Health Insurance Identification Number
(Social Security number [SSN] or Empire Plan identification number) _____

Name of Enrollee _____

Street _____

City _____ State _____ Zip _____

❑ This is a new address. Please complete Form PS-850 (see page 13).

Telephone: Day _____ Night _____
(area code) (area code)

I am writing because:

_____

_____

_____

_____

_____

_____

_____

_____

Effective date requested for change _____

Signature _____

Name (please print) _____

Dependent Name _____ SSN _____

Medicare ID number (from Medicare card) _____ Date _____

Dependent Signature (required if Medicare-primary) _____

❑ I am enclosing a photocopy of my (or my dependent's) required documentation, including Medicare card (if applicable).

❑ I have no Medicare-eligible dependents.