2008 Benefit Statement

THE EMPIRE PLAN

State of New York
Department of Civil Service
Employee Benefits Division
www.cs.state.ny.us

For Active Employees, Retirees, Vestees, and Dependent Survivors and their Dependents enrolled in The Empire Plan through Participating Agencies

Your Empire Plan benefits provided through the New York State Health Insurance Program (NYSHIP) are valuable. In order to avoid claims problems, you need to be sure your enrollment record is correct.

Your Benefit Statement (next page) shows the information on your official health insurance enrollment record maintained by the New York State Department of Civil Service, Employee Benefits Division. Every part is important. Please review your record carefully, including your address on the label.

If you have corrections, you must notify your agency Health Benefits Administrator in writing by using the Benefit Statement Correction Form on page 3. If you have corrections, you must sign and return this form with the required documents. If you do not correct errors in your record, we reserve the right to limit future corrections of this information to the date of this statement.

Active enrollees: You **must** notify your agency Health Benefits Administrator of any additions, deletions or changes by

Retirees and other non-Active enrollees: Please notify your *former* agency Health Benefits Administrator of any additions, deletions or changes by mailing your Benefit Statement Correction Form by
An envelope is enclosed for your convenience.

If your record is correct and complete, as presented on this Benefit Statement, no further action is required.

Details...

1 **The information in this statement was taken from your health insurance enrollment record on**

Make sure your statement is accurate for

Any enrollment change you requested after this date should be confirmed with your agency Health Benefits Administrator.

2 **The purpose of this Benefit Statement is to confirm your information is correct (correct records).** The only way to correct your record is to provide your agency Health Benefits Administrator with your changes in writing. You may use the Benefit Statement Correction Form on page 3.

3 **Your agency Health Benefits Administrator may need additional information from you to make changes in your records.** Please make sure you provide all the information requested.

4 **If someone other than the enrollee will be submitting changes to the information on this Benefit Statement on the enrollee's behalf, certain required documents must be on file.** If a NYSHIP enrollee wishes to have a third party act on his or her behalf regarding NYSHIP health insurance matters, a copy of Power of Attorney (POA) or legal guardianship papers must be submitted to authorize the changes. A HIPAA authorization form can be obtained from your agency Health Benefits Administrator which, when completed and filed with your agency Health Benefits Administrator, will allow the release of individually identifiable health information to persons other than the enrollee.

5 **Keep your enrollment records up to date.** Your *NYSHIP General Information Book and Empire Plan Certificate* explains how to update your coverage at any time. You can also find this information on our web site at www.cs.state.ny.us. Click on Benefit Programs then on NYSHIP Online. Select your group, if prompted, and then click on Health Benefits for links to the *NYSHIP General Information Book and Empire Plan Certificate* and to other group-specific health benefit information.

2008 Empire Plan Benefit Statement
Health Insurance Enrollment Record Information

Save this page for your records. Make corrections on the Benefit Statement Correction Form, page 3, and give it to your agency Health Benefits Administrator.

Enrollee Information

1. Name
If your first and/or last name is abbreviated, please print your full name on the Benefit Statement Correction Form on page 3.

2. Enrollee Status
(Such as PA Retiree, PA Vestee, PA Dependent Survivor, PA COBRA, etc.)

3. Social Security Number

Empire Plan Identification Number

4. Sex

5. Date of Birth

6. Marital Status (Single, Married, Divorced, Separated or Widowed)

Marital Status Date

7. Active Agency Name/Former Agency Name (for Retirees and other non-Active enrollees)

Agency Code

Health Benefit Information

8. Coverage
Individual or Family: Individual coverage provides benefits for you only. It does not cover your dependents even if they are eligible. Family coverage covers you and your eligible enrolled dependents.

9. Medicare
Indicates whether our records show that Medicare is primary to (pays before) NYSHIP. See your *NYSHIP General Information Book and Empire Plan Certificate* for more information about when Medicare is primary.

If you are an Active employee and Medicare is primary to NYSHIP for you because of end-stage renal disease, but "No" is displayed in this section, please

(continued in next column)

Medicare *(continued)*
indicate "Yes" on #9 on the Benefit Statement Correction Form on page 3, and **attach a photocopy** of your Medicare card. If you are a Retiree, Vestee or Dependent Survivor and Medicare is primary because of age, end-stage renal disease or disability, but "No" is displayed in this section, please indicate "Yes" on #9 on the Benefit Statement Correction Form on page 3, and **attach a photocopy** of your Medicare card. See your *NYSHIP General Information Book and Empire Plan Certificate* for more information about when Medicare is primary.

10. Medicare ID #

Enrolled Dependent Information

11. Name The names of the dependents currently covered on your record. If the first and/or last name is abbreviated, please print the full name on the Benefit Statement Correction Form on page 3. Please make corrections here for your records. **If you are removing a dependent, you must complete numbers 11 and 12 on the Benefit Statement Correction Form on page 3.**	**12.** Date Eligibility Changed Fill in the date (mm/dd/yyyy) of the change on page 3 if you add or remove a dependent.	**13.** Relationship Your dependent's relationship to you. "Other" will show for a dependent other than a natural, adopted or dependent stepchild.	**14.** Date of Birth* The date (mm/dd/yyyy) of birth for each dependent listed on your record.	**15.** Social Security Number (SSN) **Must** be filled in on the Benefit Statement Correction Form on page 3 if line displays "please provide" or if SSN is incorrect. The SSN is required for all dependents.	**16.** Sex M or F	**17.** Dependent Coverage End Date** End date (mm/dd/yyyy) assigned to a dependent who requires recertification for a disability or a relationship.	**18. and 19.** Dependent Medicare*** If yes, Medicare ID# and attach a photocopy of your dependent's Medicare card.

* Dependent children with Empire Plan coverage, who are age 19 or over, are not eligible unless they are unmarried full-time students or disabled (disability must be certified). You **must** remove ineligible dependents or duplicate dependent listings from your health insurance enrollment record. You **must** notify your agency Health Benefits Administrator in writing of any ineligible dependents or duplicate dependent listings.

** Certain dependent relationships and temporarily disabled dependent relationships must be recertified periodically or before the end date noted in #17.

*** Indicates whether our records show that Medicare is primary to NYSHIP for your dependent. If your dependent is enrolled in Medicare, but "No" is displayed in this section, you **must** indicate "Yes" on the Benefit Statement Correction Form, page 3, #18, enter the Medicare ID number in section #19 of the Benefit Statement Correction Form and **attach a photocopy** of your dependent's Medicare card.

2008 Empire Plan Benefit Statement Correction Form

Instructions: Using the correction form below, cross out any incorrect information. Print the change(s) or addition(s) needed to correct your enrollment file. **Sign and date** below, separate at perforation, keep page 2 for your records, and return this page to your agency Health Benefits Administrator. Retirees and other non-Active enrollees: If you have made corrections, please mail this page to your *former* agency Health Benefits Administrator. An envelope has been provided for your convenience.

EXAMPLE:
1. Name Correction: ~~JOHN DOE~~ Joseph

If you have any questions about the form or your enrollment, please contact your agency Health Benefits Administrator at the address provided on page 4.

If your statement is complete and correct, you do not have to do anything. You may save this unused form for future use.

HEALTH BENEFITS ADMINISTRATOR: Please change my health insurance enrollment record as shown below.

X_____ _____ _____

Enrollee Signature (required for any corrections) | Area Code/Telephone # (home) | Date

Enrollee Information

1. Name
Correction:_____
Please print your first name, middle initial, last name.

2. Enrollee Status
Correction:_____

3. Social Security Number
Correction:_____

4. Sex
Correction:_____

5. Date of Birth
Correction:_____

To correct your date of birth, print the correct date and **attach a photocopy** of your birth certificate, baptismal record or passport.

6. Marital Status
Correction:_____
Date of marriage, divorce or death of spouse:_____

To correct "Marital Status," print the correct status and **attach a photocopy** of your marriage certificate, divorce decree or your spouse's death certificate.

7. Active Agency Name/Former Agency Name (for Retirees and other non-Active enrollees)
Correction:_____

Health Benefit Information

8. Coverage
Correction:_____
Date of Change:_____
Explanation/Reason for Correction:_____

9. Medicare
Correction:_____

10. Medicare ID #
Correction:_____

To correct your Medicare record, **you must attach a photocopy** of your Medicare card.

Enrolled Dependent Information

11. Name The names of the dependents currently covered on your record. If the first and/or last name is abbreviated, please cross out any abbreviated or incorrect information and print the full name above the printed names. **If you are removing a dependent, draw a thin line through the dependent's name and write the reason for removal. Be sure to write in the date of removal in number 12.** (If you are unable to do this legibly in the spaces provided, please attach a separate sheet with this required information.)	**12.** Date Eligibility Changed Fill in the date (mm/dd/yyyy) of the change here and on page 2 if you add or remove a dependent.	**13.** Relationship Your dependent's relationship to you. "Other" will show for a dependent other than a natural, adopted or dependent stepchild.	**14.** Date of Birth* The date (mm/dd/yyyy) of birth for each dependent listed on your record.	**15.** Social Security Number (SSN) **Must** be filled in if line displays "please provide" or if SSN is incorrect. The SSN is required for all dependents.	**16.** Sex M or F	**17.** Dependent Coverage End Date** End date (mm/dd/yyyy) assigned to a dependent who requires recertification for a disability or a relationship.	**18. and 19.** Dependent Medicare*** If yes, **Medicare ID#** and attach a photocopy of your dependent's Medicare card.

* To correct a dependent's date of birth, show the correct date and **attach a photocopy** of the dependent's birth certificate, baptismal record or passport.

** Certain dependent relationships and temporarily disabled dependent relationships must be recertified periodically or before the end date noted in #17.

*** If Medicare is primary to NYSHIP for your dependent, but "No" is displayed in this section, please indicate "Yes" in section #18, enter the Medicare ID number in section #19 and **attach a photocopy** of your dependent's Medicare card to this form.

Tear at perforation

ADDRESS CORRECTION

Please submit the entire Benefit Statement Correction Form (page 3). We are collecting this information to update your enrollment records. The Employee Benefits Division is committed to maintaining the privacy of your health benefits information. We handle all personal health information in accordance with applicable federal and State laws.

Agency Health Benefits Administrator,
please correct my address as follows:

_____

_____

_____

_____

NYSHIP
New York State Health Insurance Program

IF YOU DO NOT HAVE BENEFIT STATEMENT CORRECTIONS

If you DO NOT have Benefit Statement corrections, STOP.
Do not submit this form.

IF YOU HAVE BENEFIT STATEMENT CORRECTIONS

YOUR CHECKLIST

If you have Benefit Statement corrections, before you submit the Benefit Statement Correction Form, please make sure you remembered to:

- ✓ Sign and date the Benefit Statement Correction Form, page 3. **Unsigned forms will be returned for signature.**
- ✓ Provide your home telephone number, including your area code.
- ✓ Attach **photocopies (on 8½" × 11" paper, please)** of any required documents that support the requested change(s).
- ✓ Check your address above to make sure it is correct and make any corrections in the space provided.
- ✓ Attach **photocopies (on 8½" x 11" paper, please)** of required Power of Attorney (POA) or legal guardianship papers if a third party is submitting changes on the enrollee's behalf.
- ✓ Keep pages 1 and 2 for your records.
- ✓ Return the Benefit Statement Correction Form, page 3, to your agency Health Benefits Administrator by

DO NOT SEND ORIGINAL DOCUMENTS