



**Personal Privacy Protection Law Notification**

The information you provide on this application is requested in accordance with Section 163 of New York State Civil Service Law for the principal purpose of administering the New York State Health Insurance Program. 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, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

I understand that any false or misleading statements made on this form will subject me to financial responsibility for any benefits paid on behalf of my 'other' child. I understand that false statements may result in disciplinary action by my employer and/or result in criminal and/or civil penalties as well as other legal actions including the prosecution of insurance fraud as defined in NYS Penal Law, Section 176.05; NYCRR, Title 11, Section 86.4 and U.S. Code, Title 18, Section 1035.

Print Enrollee Name: \_\_\_\_\_

Enrollee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Sign in the presence of notary)

**Acknowledgement to Be Completed by a Notary Public**

State of \_\_\_\_\_ County of \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/ their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Notary Public: \_\_\_\_\_  
(Please sign and affix stamp)

For Office Use Only	
<input type="checkbox"/> <b>Initial enrollment or recertification for an "other" child under the age of 19</b>	<input type="checkbox"/> Copy of the Dependent's Birth Certificate <input type="checkbox"/> Proof of Support (50% or more) <input type="checkbox"/> Health Insurance Transaction Form
<input type="checkbox"/> <b>Recertification of an "other" child who is age 19 or older</b>	<input type="checkbox"/> Copy of the Dependent's Birth Certificate <input type="checkbox"/> Proof of Dependent's Residence <input type="checkbox"/> Health Insurance Transaction Form
<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Date transaction submitted to add dependent: _____
HBA Signature: _____	Date: _____

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