State of New York
Department of Civil Service
Alfred E. Smith State Office Bldg.
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION
New York State Health Insurance Transaction Form
For April 1, 2007 Special Option Transfer Period

INSTRUCTIONS: This form is to process plan change requests for eligible enrollees only. Please complete this form according to the instructions on the back.

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 ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated	Marital Status Date	
9. Covered under Medicare? Self ☐ Yes ☐ No	Spouse/Domestic Partner ☐ Yes ☐ No	

10. ENTER PLAN CHANGE REQUEST

Current Plan:	**Change to Plan:**
HMO Code: _____	☐ Empire Plan ☐ HMO*
HMO Name: _____	HMO Code: _____
	HMO Name: _____

* ✓ ***A completed HMO form must be attached.*** If you are enrolling in a different HMO, please double check the HMO's page in the Choices booklet.
✓ Is the HMO approved by NYSHIP to serve your county?
✓ Did you complete the HMO Enrollment form and send it to the HMO?

Personal Privacy Protection Law Notification

This 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	Effective Date	Date Entered on NYBEAS	Agency Code:

HBA Signature:	**Date:**

INSTRUCTIONS

Use this form only for the Special Option Transfer Period that ends March 30, 2007. Only enrollees who will have a rate increase as a result of the new rates effective April 1, 2007 are permitted to request an option change at this time. All other enrollees must wait until the normal option transfer period in November.

If You Are Changing Your Option

1. Complete and sign the front of this form. Return it to your agency Health Benefits Administrator **no later than March 30, 2007. Late Option Transfer Forms will not be accepted and you will not be permitted to change options until the regular option transfer period in November 2007 (unless you have another qualifying event).**

2. If you are enrolling in a different HMO
   - Complete the attached **Notice of Intent to Enroll in an HMO** and return it to your agency Health Benefits Administrator along with this form.
   - Pay special attention to Health Center/Primary Physician/Pharmacy. Fill in the name of the Health Center, Primary Care Physician and Pharmacy you have chosen. Call the HMO for a list of participating providers.

IF YOU HAVE ANY QUESTIONS,

CONTACT YOUR AGENCY HEALTH BENEFITS ADMINISTRATOR,

LOCATED IN YOUR AGENCY'S PERSONNEL OFFICE.