

# NYSHIP Option Transfer Request

Please fill in this form and return it 60 days in advance or as early as possible prior to the effective date you are requesting to:

NYS Department of Civil Service Employee Benefits Division,  
Benefits Administration, Albany, New York 12239

Call us at 518-457-5754 or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands)  
if you have any questions about this form.

Enrollee Name \_\_\_\_\_

Social Security Number (SSN) \_\_\_\_\_

Address \_\_\_\_\_

County \_\_\_\_\_ City or Post Office \_\_\_\_\_

State \_\_\_\_\_ ZIP Code \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

Is this a new address?  Yes  No Date of New Address: \_\_\_\_\_

Medicare  Yes  No

If Yes: Part A Effective Date: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_

Dependent Medicare  Yes  No

If Yes: Part A Effective Date: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_

Are you or your dependent reimbursed from another source for Part B coverage?  Yes  No

If Yes, by whom? \_\_\_\_\_ Amount \$ \_\_\_\_\_

Effective \_\_\_\_\_ 1, 20\_\_\_\_\_, please change my health insurance option  
(month) (year)

From: Current Option Code Number \_\_\_\_\_ Current Plan Name \_\_\_\_\_

To: New Option Code Number \_\_\_\_\_ New Plan Name \_\_\_\_\_

Date \_\_\_\_\_ Enrollee Signature (required) \_\_\_\_\_

**If you have Family coverage, please complete the following for each dependent enrolled in Medicare.**

(Attach a separate sheet of paper if necessary.)

Dependent Name \_\_\_\_\_ SSN \_\_\_\_\_

Medicare ID # (on his or her Medicare card) \_\_\_\_\_ Date \_\_\_\_\_

Dependent Signature (required) \_\_\_\_\_

Dependent Name \_\_\_\_\_ SSN \_\_\_\_\_

Medicare ID # (on his or her Medicare card) \_\_\_\_\_ Date \_\_\_\_\_

Dependent Signature (required) \_\_\_\_\_

I have no Medicare-eligible dependents

If you are enrolling in an HMO, is the HMO approved by NYSHIP to serve your county?  
Please double check the HMO's page in this booklet.

No action is required if you wish to keep your current health insurance.

**USE THIS FORM FOR OPTION CHANGE ONLY**



## When You Are Enrolled in Medicare and You Leave an HMO

If you or your dependent is enrolled in Medicare and you change out of one of the following NYSHIP Medicare Advantage HMOs...

Option 210	Aetna
Option 066	Blue Choice
Option 067	BlueCross BlueShield of Western New York
Option 063	CDPHP
Option 300	CDPHP
Option 310	CDPHP
Option 280	Empire BlueCross BlueShield HMO
Option 290	Empire BlueCross BlueShield HMO
Option 320	Empire BlueCross BlueShield HMO
Option 050	HIP Health Plan of New York
Option 059	Independent Health
Option 058	MVP Health Care (Rochester)
Option 060	MVP Health Care (East)
Option 330	MVP Health Care (Central)
Option 340	MVP Health Care (Mid-Hudson)

**...you must fill out the form on the opposite page and send it to the HMO you are leaving prior to the effective date you are requesting.** (The requested effective date must be the first of a month.) Use the address that appears on the appropriate HMO page.

**Act quickly! If you do not fill out this form and mail it to the HMO prior to the effective date you are requesting, you may have claim problems with your new NYSHIP plan.** You may be responsible for the full cost of services that would have been covered by Medicare.