

10. Continued.								ENTER REQUEST(S) BELOW							
H. <input type="checkbox"/> Change NYSHIP Option				Change to: <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code <input type="text"/>				HMO Name <input type="text"/>				Opt-Out <input type="checkbox"/>			
I. Change Pre-Tax Status				Change to: <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax				Processed only by the Employee Benefits Division during the Pre-Tax Contribution Selection Period (November)							
11. PREVIOUS COVERAGE INFORMATION															
If you were previously enrolled in a NYSHIP plan, or were covered another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.				Previous ID Number				Date the other coverage terminated							
				Enrollee's Name Under Which Previously Covered				Last		First		Middle Initial			
12. LEAVE WITHOUT PAY AND RETIREMENT STATUS															
LEAVE WITHOUT PAY				<input type="checkbox"/> I wish to continue coverage while I am on authorized leave. I understand that I will be billed for this coverage.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision							
				<input type="checkbox"/> I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision							
RETIREMENT				<input type="checkbox"/> I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage.											
				<input type="checkbox"/> I understand the requirements for continuing medical insurance coverage as a retiree and wish to defer my coverage. (A completed PS-406.2 must be attached.)											
13. REQUEST FOR EMPIRE PLAN CARD ONLY															
For Health Maintenance Organization (HMO) cards, contact your HMO.															
<input type="checkbox"/> DUPLICATE CARD (Previously issued card remains valid.)				FOR				<input type="checkbox"/> ENROLLEE				<input type="checkbox"/> ENROLLEE AND ALL DEPENDENTS			
								<input type="checkbox"/> INDIVIDUAL DEPENDENT				Name <input type="text"/>			
Personal Privacy Protection Law Notification															
The 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 am aware of how to obtain a current <i>Summary of Benefits and Coverage</i> for the NYSHIP option I have selected. 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		Hire Date		Date of 1 st Eligibility (PE only)		Percentage Working		Agency Code		Neg. Unit		Ret. System	
Retirement Tier		Registration #		Sick Leave Information # Hours Hourly Rate of Pay				Date Entered on NYBEAS		Effective Date					
		<input type="text"/>													
HBA Signature:												Date:			