NEW YORK STATE OF OPPORTUNITY. **Department of Civil Service**

EMPLOYEE BENEFITS DIVISION
NYS Health Insurance Transaction Form for Retirees, Vestees, Preferred List and Dependent Survivors

PS-404R (3/18)

INSTRUCTIONS: READ AND COMPLETE BOTH PAGES. PRINT AND CHECK THE APPROPRIATE CHOICES AND SIGN/DATE THE DOCUMENT.

ENROLLEE INFORMATION *(All enrollees must complete)*

1. Last Name | First Name | MI

2. Social Security Number

3. Sex ☐ Male ☐ Female

4. Mailing Address | City | State | Zip

Street Address ☐ Check box if same as Mailing address | City | State | Zip

5. Date of Birth

6. Telephone Number
Home ( ) Cell ( )

7. Is any of this information new?
☐ Yes ☐ No
Effective Date of Change: _____

8. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Marital Status Date

9. Covered under Medicare? Self: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No Child: ☐ Yes ☐ No

10. ENROLL IN COVERAGE

A. Individual Enrollment	☐ Empire Plan ***Or*** ☐ HMO Code: ☐ Name: _____
B. Family Enrollment *(Complete Box 12)*	☐ Empire Plan ***Or*** ☐ HMO Code: ☐ Name: _____

11. CHANGE OR CANCEL EXISTING COVERAGE

A. Change Coverage **Date of Event:** _____

☐ **Change to FAMILY** *(Complete Box 12)*
- ☐ Marriage
- ☐ Domestic Partner
- ☐ First dependent child acquired
- ☐ Request coverage for dependents not previously covered
- ☐ Newborn
- ☐ Previous coverage terminated *(Complete Section 13)*
- ☐ Other _____

☐ **Change to INDIVIDUAL**
- ☐ I voluntarily cancel coverage for my dependents
- ☐ I voluntarily cancel coverage for my domestic partner
- ☐ Only dependent died
- ☐ Divorce
- ☐ Only dependent disqualified by age
- ☐ Termination of domestic partnership *(Attach Completed PS-425.4)*
- ☐ Other _____

B. Voluntarily Cancel Coverage	☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* **Request Date:** _____
C. Change NYSHIP Option to	☐ Empire Plan ***Or*** ☐ HMO Code ☐ HMO Name _____

12. DEPENDENT INFORMATION

Must be provided when choosing to enroll or opt-out of NYSHIP family coverage *(use additional sheets if necessary)*

Check One: A (Add), D (Delete) or C (Change) **Date of Event:** _____

	Last Name	First Name	MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security Number
☐ A ☐ D ☐ C								
☐ A ☐ D ☐ C								
☐ A ☐ D ☐ C								

Proof required when adding a dependent is as follows:		
Spouse	**Domestic Partner**	**Child**
1. Copy of Birth Certificate	1. Copy of Birth Certificate	1. Copy of Birth Certificate
2. Copy of Social Security Card (Copy of Medicare Card if applicable)	2. Social Security Number (Copy of Medicare Card if applicable)	3. Social Security Number (Copy of Medicare Card if applicable)
3. Copy of Marriage Certificate (if the marriage took place more than one year ago — see #4 below)	4. Completed PS-425 Domestic Partner application and acceptable proof as defined in the application.	2. For children over 26, approved PS-451 Statement of Disability Form.
4. For marriages that took place more than one year ago, proof of current joint ownership/joint financial obligation is required (i.e.: prior year's tax return). If tax document is not provided, a current bank statement, mortgage statement or homeowner's policy may be provided.		3. For Relationship of 'Other', a completed PS-457 Statement of Dependence is required along with acceptable proof as defined in the PS-457.

13.	**PREVIOUS COVERAGE INFORMATION**	
If you were previously enrolled in a NYSHIP plan, or were covered by another health insurance plan, please complete this section. (attach proof, i.e. insurance bill or letter stating former coverage)	Previous ID Number	Date the other coverage terminated
	Enrollee's Name Under Which Previously Covered — Last	First MI

14. REQUEST FOR EMPIRE PLAN CARD ONLY

☐ DUPLICATE CARD
(Previously issued card remains valid.)

FOR

☐ ENROLLEE
☐ ENROLLEE AND ALL DEPENDENTS
☐ INDIVIDUAL DEPENDENT
Name _____

For Health Maintenance Organization (HMO) cards, contact your HMO.

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 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 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.

AUTHORIZATION

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. I am aware of how to obtain a current *Summary of Benefits and Coverage* 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 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 Signature (Required): _____ **Date:** _____