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,
Program 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) _____

Mailing Address _____

County _____ City or Post Office _____

State _____ ZIP Code _____ Telephone Number (_____) _____

Is this a new address? ❑ Yes ❑ No Date of New Address: _____

Residential Street Address (if different) _____

County _____ City or Post Office _____

State _____ ZIP Code _____

Medicare ❑ Yes ❑ No If Yes, Effective Dates: Part A _____ Part B _____

Dependent Medicare ❑ Yes ❑ No If Yes, Effective Dates: Part A _____ Part B _____

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 check the NYSHIP Options by County guide.

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

USE THIS FORM FOR OPTION CHANGE ONLY