State of New York
Department of Civil Service
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION
NYS HEALTH INSURANCE TRANSACTION FORM
YOUNG ADULT DEPENDENT
11/2010

ENROLLEE INFORMATION

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. Dependent is currently covered under NYSHIP through the Young Adult Option (YAO) or COBRA Health Insurance paying full share premium and wishes to terminate this coverage to enroll as a dependent under parent's coverage:
Check one: Yes ☐ No ☐ If yes, both enrollee and dependent must sign below.

ADULT CHILD DEPENDENT INFORMATION (use additional sheets if necessary)

Check One: A (Add), or C (Change TO FAMILY COVERAGE)

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

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, New York State 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 certify that the information I have supplied is true and correct. 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.

→ Enrollee's Signature (Required) _____ Date (Required) _____
Dependent's Signature _____ Date_____
(Required if choosing to cancel YAO or COBRA coverage)

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Agency Code	Date Entered on NYBEAS
Health Benefits Administrator Signature Required:			Date:

See Reverse Side for Instructions