

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, Operations Unit
Alfred E. Smith State Office Building
Albany, New York 12239

Call us at 518-457-5754 (Albany area) 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, please double check the HMO's page in this booklet. Is the HMO approved by NYSHIP to serve your county?

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

USE THIS FORM FOR OPTION CHANGE ONLY

