Department of Civil Service
Employee Benefits Division

PS-157 (2/2026)
NYS Dependent Survivor Transaction Form
Department of Civil Service, Albany, NY 12239

INSTRUCTIONS: Complete all missing information. Sign and date this form. Make a copy for your records. Return the form to the address below. ***Any person who knowingly files an application for insurance containing false information, or conceals information, commits a fraudulent insurance act, which is a crime.***

New York State Department of Civil Service
Employee Benefits Division
Albany, NY 12239

1–9 SURVIVOR INFORMATION (YOU ARE THE ENROLLEE)

1. Last Name　First Name　MI

2. Social Security Number ___ – __ – ____　**3.** Gender ☐ F ☐ M ☐ X

4. Permanent Address　Street　City　State　Zip

5. Mailing Address *(If different)*　Street　City　State　Zip

6. Date of Birth __ / __ / ____　**7.** Telephone Primary (　)　Cell (　)

8. Personal Email Address

9. Covered under Medicare?
- ☐ Self　Medicare ID Number　Date __ / __ / ____
- ☐ Dependent　Dependent Name ______________________
  Medicare ID Number ______________________　Date __ / __ / ____

10 ENROLL IN COVERAGE

10. Select a NYSHIP Plan Option *(Choose option 1 or 2)*

1. Individual Enrollment *(Select Empire Plan or HMO)*
   ☐ Empire Plan ☐ HMO　Code ________　HMO Name ______________
2. Family Enrollment *(Complete box 11) (Select Empire Plan or HMO)*
   ☐ Empire Plan ☐ HMO　Code ________　HMO Name ______________

11 ADDITIONAL ELIGIBLE DEPENDENT(S) INFORMATION

Dependent Eligibility is defined in your ***NYSHIP General Information Book*****. Additional eligible dependents may be added with PS-404S Additional Dependent Information Supplement if necessary.**

Last Name ______________ First Name ______________ MI ____ Relationship ________
Date of Birth __ / __ / ____　Gender ☐ F ☐ M ☐ X　Social Security Number ___ – __ – ____
Address *(if different)* ______________________________

Last Name ______________ First Name ______________ MI ____ Relationship ________
Date of Birth __ / __ / ____　Gender ☐ F ☐ M ☐ X　Social Security Number ___ – __ – ____
Address *(if different)* ______________________________

Last Name ______________ First Name ______________ MI ____ Relationship ________
Date of Birth __ / __ / ____　Gender ☐ F ☐ M ☐ X　Social Security Number ___ – __ – ____
Address *(if different)* ______________________________

☐ If you have additional dependents, please check this box and attach PS-404S with their information.

15 NOTIFICATION PREFERENCES

To change how you receive NYSHIP publications, select one option below. If no option is selected, you will continue to receive mail only. A valid personal email is required for email delivery. Some communications must be sent by mail.

☐ I would like to receive publications by email only. ☐ I would like to receive publications by email and mail.

If you check "I would like to receive publications by email only," you will stop receiving NYSHIP publications by mail. Some required communications may still be mailed. If you check "I would like to receive publications by email and mail," you will receive NYSHIP publications by email and mail. If you do not check a box, you will continue to receive publications by mail only.

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

The information you provide on this application is being requested in accordance with Article 11 of the Civil Service Law for the principal purpose of enabling the Department of Civil Service to institute changes in health insurance coverage. The 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 result in the disapproval of your application. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, Albany, NY 12239. For information concerning the Personal Privacy Protection Law, call (518) 457-9375. For information related to the New York State Health Insurance Program, please call 1-800-833-4344 between the hours of 9:00 a.m. and 4:00 p.m.

AUTHORIZATION

I understand that the information I have supplied is true and correct. I understand new Empire Plan Identification card(s) will be sent to me about four weeks after my application is processed. HMO identification card(s) are sent directly by the HMO.

▶ **Signature (Required)** ______________________________ Date __ __ / __ __ / __ __ __ __

AGENCY USE ONLY

Agency Code	Initials	Process Date