PS-404 Updated: 10/2026

Department of Civil Service
Employee Benefits Division

NYSHIP Health Insurance Transaction Form for NYS & PE Employees

This form is for enrollment in and changes to your NYSHIP plan option, coverage type or pre-tax status. It is also for adding and removing dependents. **Leave blank any sections that do not pertain to your transaction.** Send the signed, completed form to your health benefits administrator (HBA). For information on eligibility and when you can make changes, see your *General Information Book* (GIB) or visit nyship.ny.gov.

1 Employee Information

Personal

Last Name _____ First Name _____ MI _____

Gender ☐ F ☐ M ☐ X Date of Birth __/__/____ Social Security Number ___-__-____

Home Address Street _____ City _____ State _____ ZIP _____

Mailing Address *(if different)* Street _____

Apt _____ Floor _____ PO Box _____ City _____ State _____ ZIP _____

Phone Number Primary (___) _____ Work (___) _____

Personal Email _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Medicare Information Medicare ID Number _____ Enrollment Date __/__/____

Are you, the enrollee, reimbursed for Medicare by another entity? ☐ Yes ☐ No

Is any of the above information new? ☐ Yes ☐ No

If yes, explain: _____ Effective Date of Change __/__/____

2 Enroll In, Change or Decline Coverage

If you leave a row blank, no change will be made to that form of coverage. If you are newly enrolling in Family coverage or changing your coverage type, you must complete Section 4 (Dependent Transaction Information). If you no longer have any eligible dependents, you must request a change from Family to Individual coverage.

MEDICAL	**Coverage Type:**	☐ Decline Coverage	☐ Individual Coverage	☐ Family Coverage
	Plan Options:	☐ The Empire Plan	☐ NYSHIP HMO	
		HMO Name _____	HMO Code _____	
		☐ Opt-Out Program (NYS only)		
		You must also complete the *NYSHIP Opt-Out Program Attestation Form* (PS-409).		
DENTAL	**Coverage Type:**	☐ Decline Coverage	☐ Individual Coverage	☐ Family Coverage
VISION	**Coverage Type:**	☐ Decline Coverage	☐ Individual Coverage	☐ Family Coverage

3 Choose Pre-Tax or After-Tax Status (NYS Only)

You may only make a tax status election if newly eligible for coverage or during Open Enrollment. If you are enrolled in the the Pre-Tax Contribution Program (PTCP), you may only make certain coverage changes during Open Enrollment or when experiencing a PTCP qualifying event (if you submit within 30 days of the event).

☐ **Pre-tax status** for premium deduction ☐ **After-tax status** for premium deduction

4 Dependent Transaction Information

Dependent information is required if you have or are changing to Family coverage. If adding/removing a dependent, also check the appropriate box. **See documentation required on page 4.**

Dependent's Personal Information

Last Name _____ First Name _____ MI ____ Relationship _____

Gender ☐ F ☐ M ☐ X Date of Birth __/__/____ Social Security Number ___-__-____

Medicare Information Medicare ID Number _____ Enrollment Date __/__/____

Is this dependent reimbursed for Medicare by another entity? ☐ Yes ☐ No

Remove this dependent due to:

☐ Divorce
☐ Domestic partnership terminated
☐ Voluntarily coverage cancellation
☐ Deceased

☐ Other _____

Add this dependent due to:

☐ New marriage
☐ New domestic partner
☐ Newborn child
☐ Currently eligible dependent not already covered
☐ Previous coverage was terminated

☐ Other _____

Date of Qualifying Event Indicated Above __/__/____

Check which coverage(s) this transaction applies to: ☐ Medical ☐ Dental ☐ Vision

☐ If you have additional dependents, please check this box and attach a *NYSHIP Health Insurance Transaction Form Additional Dependent Information Supplement* (PS-404S) with their information.

5 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 (see Section 1). 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**.

6 Donate Life Registry Election

This question must be answered each time the form is filled out.

Would you like to be added to the Donate Life Registry? ☐ Yes ☐ Skip this question

By indicating "yes," you are certifying that you are 16 years of age or older, consenting to donate your organs and tissues for the purposes of transplantation and research in the event of your death and authorizing NYSHIP to share your name and identifying information with the Registry.

ID Number on New York State Driver License, Learner Permit or Non-Driver ID Card _____

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Personal Privacy Protection Law Notification

The 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, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; 518-473-1977. For information relating only to the Personal Privacy Protection Law, call 518-457-9375.

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Authorization

This authorization is made now for future deductions that will occur at the time of retirement. Pursuant to the following Sections of NYS Retirement and Social Security Law: 110-a; 110-b; 110-c; 110-d; 410-a; 410-b or 410-c, I hereby authorize the NYS Department of Civil Service (DCS) to deduct an amount from my monthly retirement allowance from the New York State and Local Retirement Systems (NYSLRS) to cover any deductions for insurance premiums payable on behalf of DCS. Authorization is given to make any future adjustment deductions and/or changes DCS certifies to NYSLRS as necessary in the amount of such insurance premiums. I understand that all requests to begin, modify or revoke deductions must be submitted to my current/former agency and provided to DCS. This authorization shall remain in effect until revoked by me by written notice or until otherwise revoked pursuant to law.

I understand that, if my coverage is declined or canceled, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date and may forfeit the right to such coverage after leaving State service (vest, retirement, etc.). I am aware of how to obtain a current *Summary of Benefits and Coverage* for the NYSHIP option I have selected. I understand that my failure to provide required proof(s) within 30 days 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 certify that the information I have supplied is true and correct. I hereby authorize deduction from my salary or retirement allowance of the amount required, if any, for the coverage indicated above.

▶ **Employee Signature (Required)** _____ Date __/__/____

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HBA Use Only

Retirement Tier	Registration	Sick Leave Information		Date Entered on NYBEAS	Effective Date
		# Hours	Hourly Rate of Pay		

▶ **HBA Signature (Required)** _____ Date __/__/____

Documentation Required for Each Type of Transaction (multiple transactions may apply)

Submit all required documentation with your completed form. If more than one category applies, submit all required documentation for each.

If you are a NEW ENROLLEE:
- Copy of birth certificate
- Copy of Social Security card
- Copy of Medicare card (if applicable)

To ADD a spouse:
- Copy of birth certificate
- Social Security number
- Copy of Medicare card (if applicable)
- Copy of marriage certificate

If marriage took place more than one year ago:
- Proof of current joint financial obligation (e.g., prior year's tax return, a current bank statement, mortgage statement or homeowner's policy)

To ADD a domestic partner:
- Copy of birth certificate
- Social Security number
- Copy of Medicare card (if applicable)
- Completed *NYSHIP Domestic Partner Enrollment Application* (PS-425) and acceptable proof as defined within

To ADD a child:
- Copy of birth certificate
- Social Security number
- Copy of Medicare card (if applicable)

For adopted children, also:
- Adoption papers (if adoption is pending, proof of pending adoption)

For children over 26, also:
- Approved *NYSHIP Statement of Disability for Dependents* (PS-451)

For "other" child, also:
- Completed *Enrollment or Recertification of an "Other" Child as a NYSHIP Dependent Form* (PS-457)
- Proofs listed within PS-457

For a child who is a full-time student over age 26 with military service, also:
- Written documentation from the U.S. military showing dates of active service
- Proof of full-time student status from an accredited secondary or preparatory school, college or educational institution

If previous coverage was terminated:
- Proof of loss of other coverage **(if not newly eligible or in Open Enrollment, submit this form and proof within 30 days to avoid a three-month waiting period)**

If REMOVING a spouse after divorce:
- Copy of the divorce decree

If REMOVING a domestic partner after the partnership is terminated:
- *Termination of Domestic Partnership for NYSHIP Form* (PS-425.4)

If REMOVING a deceased dependent:
- Copy of the death certificate