NEW YORK STATE OF OPPORTUNITY. **Department of Civil Service**

EMPLOYEE BENEFITS DIVISION
NYSHIP Health Insurance Transaction Form
for NY/PE Retirees, Vestees, Preferred List and Dependent Survivors

PS-404R (1/2023)

INSTRUCTIONS: READ AND COMPLETE BOTH PAGES. PLEASE PRINT, CHECK THE APPROPRIATE CHOICES AND SIGN/DATE THE DOCUMENT.

ENROLLEE INFORMATION

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 Numbers Home ( )	Cell ( )	
8. Personal Email Address			
9. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated			Marital Status Date
10. Covered under Medicare? ☐ Self	Medicare ID Number: _____		Date: _____
☐ Dependent	Medicare ID Number: _____ Dependent Name: _____		Date: _____
11. Is any of this information new? ☐ Yes ☐ No	Box Number(s): _____	Effective Date of Change: _____	

12. ENROLL IN COVERAGE

A. Individual Enrollment	☐ Empire Plan ***or*** ☐ HMO Code: ☐	HMO Name: _____
B. Family Enrollment *(Complete box 13)*	☐ Empire Plan ***or*** ☐ HMO Code: ☐	HMO Name: _____

13. DEPENDENT INFORMATION

Must be provided when choosing to enroll in family coverage *(use additional sheets if necessary)*

Check One: A (Add), D (Delete) or C (Change) **Date of Event:** _____

	Last Name First Name MI	Relationship	Date of Birth	Gender	Address *(if different)*	Social Security Number
☐ A ☐ D ☐ C				☐ F ☐ M ☐ X		
☐ A ☐ D ☐ C				☐ F ☐ M ☐ X		
☐ A ☐ D ☐ C				☐ F ☐ M ☐ X		

14. CHANGE OR CANCEL EXISTING COVERAGE

A. Change Coverage **Date of Event:** _____

☐ **Change to FAMILY** *(Complete box 13)*

- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Other _____

☐ **Change to INDIVIDUAL**

- ☐ Divorce
- ☐ Termination of domestic partnership *(Attach Completed PS-425.4)*
- ☐ I voluntarily cancel coverage for my dependents
- ☐ Only dependent died
- ☐ Only dependent ineligible due to age
- ☐ Other _____

B. Voluntarily Cancel Coverage	☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)*	Request Date: _____
C. Change NYSHIP Option	☐ Empire Plan ***or*** ☐ HMO Code: ☐	HMO Name _____

Proof required when adding a dependent is as follows:		
Spouse	**Domestic Partner**	**Child**
1. Copy of Birth Certificate	1. Copy of Birth Certificate	1. Copy of Birth Certificate
2. Social Security Number (copy of Medicare Card if applicable)	2. Social Security Number (copy of Medicare Card if applicable)	3. Social Security Number (copy of Medicare Card if applicable)
3. Copy of Marriage Certificate (if the marriage took place more than one year ago — see #4 below)	4. Completed PS-425 Domestic Partner application and acceptable proof as defined in the application.	2. For children over 26, approved PS-451 Statement of Disability Form.
4. For marriages that took place more than one year ago, proof of current joint ownership/joint financial obligation is required (i.e.: prior year's tax return). If tax document is not provided, a current bank statement, mortgage statement or homeowner's policy may be provided.		3. For Relationship of 'Other' Child, a completed PS-457 Statement of Dependence is required along with acceptable proof as defined in the PS-457.

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. For information related to the Health Insurance Program, contact the Employee Benefits Division at (518) 457-5754 or 1-800-833-4344.

AUTHORIZATION

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 DCS is my agent and all requests to begin, modify, or revoke deductions must be submitted to DCS. This authorization shall remain in effect until revoked by me by written notice to DCS 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. 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 retirement allowance of the amount required, if any, for the coverage indicated above.

Enrollee Signature (Required): _____ **Date:** _____