Department of Civil Service
Employee Benefits Division

PS-404R (1/2025)

NYSHIP Health Insurance Transaction Form for NYS & PE Retirees, Vestees, Preferred List and Dependent Survivors

Department of Civil Service, Albany, NY 12239

INSTRUCTIONS: Read and complete both pages. Please print, check the appropriate choices and sign/date the document.

1–12 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 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 Dependent Name ________________
Medicare ID Number ________________ Date _ _ / _ _ / _ _ _ _

11. Is any of this information new? ☐ No ☐ Yes Box Number(s) ________ Effective Date of Change _ _ / _ _ / _ _ _ _

12 ENROLL IN COVERAGE

A. Individual Enrollment
☐ Empire Plan ☐ HMO Code ________ HMO Name ________________

B. Family Enrollment *(Complete box 13)*
☐ Empire Plan ☐ HMO Code ________ HMO Name ________________

13 DEPENDENT INFORMATION

Must be provided when choosing to enroll or opt-out of NYSHIP family coverage
(You may attach additional sheets if necessary) Date of event _ _ / _ _ / _ _ _ _

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update

Last Name ________________ First Name ________________ MI ____ Relationship ________

Date of Birth _ _ / _ _ / _ _ _ _ Gender ☐ F ☐ M ☐ X Social Security Number _ _ _ – _ _ – _ _ _ _

Address *(if different)* ________________

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update

Last Name ________________ First Name ________________ MI ____ Relationship ________

Date of Birth _ _ / _ _ / _ _ _ _ Gender ☐ F ☐ M ☐ X Social Security Number _ _ _ – _ _ – _ _ _ _

Address *(if different)* ________________

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update

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 additional sheets with their information.

14 CHANGE OR CANCEL EXISTING COVERAGE

14A. Change Coverage Date of Event _ _ / _ _ / _ _ _ _

☐ **Change to FAMILY** *(Complete box 14 on page 1)*	☐ **Change to INDIVIDUAL**
☐ Marriage	☐ Divorce
☐ Domestic Partner	☐ Termination of Domestic Partnership *(Attach completed PS-425.4)*
☐ Newborn	☐ Only dependent ineligible due to age
☐ Request coverage for dependents not previously covered	☐ I voluntarily cancel coverage for my dependents
☐ Previous coverage terminated *(proof required)*	☐ Only dependent died
☐ Other_____	☐ Other_____

NOTE: If you are indicating a change in marital status to Divorced or Separated, please be sure to update the address information for the dependent in box 13 if applicable. Final divorce decrees (first and last page) are required.

14B. Voluntarily Cancel Coverage ☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* Request Date _ _ / _ _ / _ _ _ _

14C. Change NYSHIP Option Change to: ☐ Empire Plan ☐ HMO Code _____ HMO Name_____

15 DONATE LIFE REGISTRY ELECTION

You must fill out the following section. 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 in response to the question asking if you would like to be added to the Donate Life Registry, 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 _____

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** _ _ / _ _ / _ _ _ _

NEW YORK STATE | Department of Civil Service
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NYSHIP PROGRAM INFORMATION RESOURCES

To enroll in benefits or to change your current benefits, you will most likely be required to submit additional forms and proofs of eligibility for coverage or evidence of a qualifying event with the completed and signed NYSHIP *Health Insurance Transaction Form* PS-404R. Learn more about these additional requirements in the following publications:

- ***General Information Book (GIB)***
  Eligibility, enrollment, required forms and proofs of eligibility
- ***Choices***
  Your plan options under NYSHIP (Empire Plan or NYSHIP HMO) and the benefits included with each one

ENROLLEE INFORMATION

Boxes 1–11	Enrollee Information	You must complete boxes 1–10 with your personal information. In Box 11, indicate if any of the information in Boxes 1 – 10 is new and needs to be updated on your NYSHIP record. Please also indicate which of the boxes contains updated information and a date of the change (if applicable). **NOTE:** Use the Marital Status Date to show the date of marriage, separation or divorce when any of those marital statuses are selected.

ENROLL IN COVERAGE

NOTE: If you choose a NYSHIP HMO, the HMO may require you to complete an additional enrollment form.

Boxes 12 A 12 B	Enroll in Coverage	You may enroll in Individual coverage or Family coverage.
Box 12 A	Individual Enrollment	Check Empire Plan or HMO box to enroll in Individual coverage.
Box 12 B	Family Enrollment	Check Empire Plan or HMO box to enroll in Family coverage.

DEPENDENT INFORMATION

Box 13	Dependent Information	Check the box to add or delete a dependent or to change a dependent's information. Complete all dependent information. Additional documentation may be required to add the dependent.

EXAMPLES OF DOCUMENTATION REQUIRED TO PROCESS YOUR TRANSACTION

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)	2. 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)	3. Completed PS-425 Domestic Partner application and acceptable proof as defined in the application.	3. 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.		4. For Relationship of 'Other' Child, a completed PS-457 Statement of Dependence is required along with acceptable proof as defined in the PS-457.

CHANGE OR CANCEL EXISTING COVERAGE

Box 14 A	Change Coverage	Check this box to change from Individual to Family or from Family to Individual coverage. You may change coverage once at any time during a 12-month period, or within 30 days of a qualifying event (check the qualifying event and enter the Date of Event). In the event that you are indicating a change in your marital status to divorced or separated, please update the dependent's new address, if applicable, in the Dependent Information section (Box 13).
Box 14 B	Voluntarily Cancel Coverage	You are entitled to make separate decisions regarding your medical, dental and vision coverage. You may cancel your medical, dental or vision coverage at any time during the year. If you are a retiree and you decide to reenroll after canceling, you may be subject to a three-month late enrollment waiting period before coverage becomes effective. If you are a vestee or COBRA, you may not be able to reenroll.
Box 14 C	Change NYSHIP Option	You may change options once at any time during a 12-month period, or within 30 days of a qualifying event (for example, change of address outside of HMO area).

DONATE LIFE REGISTRY ELECTION

Box 15	Donate Life Registry Election	**DONATE LIFE REGISTRY:** Check box for 'Yes' or 'Skip this question.' **This question must be answered each time the form is filled out.** If you check the box marked 'Yes', you are indicating your consent to enroll in the Donate Life Registry. You understand that by enrolling in the Registry, you are giving legal consent to the donation of your organs, tissues and eyes in the event of your death. You authorize access to the information as needed for the administration of the Registry and to federally regulated organ procurement organizations, New York State licensed tissue and eye banks, and entities formally approved by the NYS Commissioner of Health at or near the time of your death. **NYS DMV ID:** If you check the 'Yes' box, it is recommended that you provide an ID number from your New York State Driver License, Learner Permit, or Non-Driver ID card. If you check the 'Skip this question' box, skip this section.

AUTHORIZATION

YOU MUST SIGN AND DATE THIS FORM.