



**INSTRUCTIONS:** Complete this form along with PS-404, PS-404R, PS-404G or PS-503 to include information for additional dependents.

**ENROLLEE INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

**DEPENDENT INFORMATION**

**NOTE:** Dental and Vision coverage are only available to NYS and PE Employees.  
Refer to PS-404 Instructions for more information.

Date of event \_\_\_ / \_\_\_ / \_\_\_\_\_

**CHECK ALL THAT APPLY:**  Add  Remove  Update **CHECK ALL THAT APPLY:**  Medical  Dental  Vision

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 **CHECK ALL THAT APPLY:**  Medical  Dental  Vision

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 **CHECK ALL THAT APPLY:**  Medical  Dental  Vision

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 **CHECK ALL THAT APPLY:**  Medical  Dental  Vision

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 **CHECK ALL THAT APPLY:**  Medical  Dental  Vision

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 **CHECK ALL THAT APPLY:**  Medical  Dental  Vision

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Relationship \_\_\_\_\_

Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_\_ Gender  F  M  X Social Security Number \_\_\_ - \_\_\_ - \_\_\_\_\_

Address (if different) \_\_\_\_\_