NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE BENEFITS DIVISION

NYSHIP Health Insurance Deferral Election Form

PS-406.2 (6/2020 L)

Information for Employees Eligible to Defer Health Insurance Coverage and Sick Leave Credit Calculation Indefinitely in Retirement

- Enrollees who have health insurance coverage through their post-retirement employment, or through their spouse's employer, are eligible to defer indefinitely the activation of their New York State Health Insurance Program (NYSHIP) coverage as retirees.
- Please refer to your NYSHIP General Information Book or ask your Health Benefits Administrator (HBA) for information on the benefits of deferring your NYSHIP coverage as a retiree.
- If you wish to defer your retiree health insurance coverage, furnish proof to your HBA that you have coverage through post-retirement employment, or through your spouse's health care plan, and complete the form below. Keep a copy of the completed form for your records.

Note: A health insurance ID card will only be acceptable as proof of coverage if it contains the deferred enrollee's name.

ENROLLMENT

☐ I have read the information provided to me regarding Deferred Health Insurance Coverage for Retirees. I wish to defer my New York State Health Insurance Program Coverage, understanding that I may defer only once.

Last Date of Active Coverage: _____
(Month / Day / Year)

NYS Department of Civil Service
Employee Benefits Division
Program Administration Unit
Empire State Plaza, Core Building 1
Albany, NY 12239

I understand that if I pre-decease my spouse and/or other eligible dependent(s) while coverage is deferred, they may transfer back to the New York State Health Insurance Program. My eligible survivor(s) should send a written request for enrollment to the Employee Benefits Division, at the above address within 90 days of my death.

I understand that I may reactivate my enrollment in the New York State Health Insurance Program at any time, by writing to the Employee Benefits Division, at the above address.

Check One:
☐ Proof of my continued coverage in my spouse's health care plan is attached.
☐ Proof of my coverage through post-retirement employment is attached.

Enrollee Name: (Please Print)	**Social Security Number:**
Enrollee Signature:	**Date:**
Agency Name:	**Agency Code:**
HBA Name: (Please Print)	**HBA Phone Number:**
HBA Signature:	**Date:**

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.

You will also need to complete a NYSHIP Sick Leave Credit Preservation Form PS-410

Please make a copy of this signed election form for your records.