



This form documents your sick leave credit if you are not electing New York State Health Insurance Program (NYSHIP) retiree coverage upon separating your employment. Ask your agency's Health Benefits Administrator to complete this form and be sure to keep a copy of the completed form for your records.

Refer to your *General Information Book* for Retirees for information including details on how to enroll in NYSHIP coverage at a later date. For questions regarding eligibility for or enrollment in NYSHIP coverage, contact the Employee Benefits Division Monday through Friday, 9 a.m. to 4 p.m. Eastern time, at 518-457-5754 or 1-800-833-4344.

**ENROLLEE INFORMATION**

Last Name _____		First Name _____		MI _____
Street Address _____		City _____	State _____	Zip _____
Health Insurance ID Number _____		Telephone Primary (    ) _____		
Annual Salary _____		Standard Hours Worked Per Week _____		
Sick Leave Credit Hours <small>Nearest Tenth</small> _____		Sick Leave Type <input type="checkbox"/> Single Annuitant <input type="checkbox"/> Dual Annuitant		
Negotiating Unit _____		Negotiating Unit Code _____		
Retirement System _____		Retirement Registration Number _____		
Agency Name _____		Agency Code _____		

**IF COVERED UNDER ANOTHER NYSHIP CONTRACT**

Contract Holder's Name \_\_\_\_\_

Contract Holder's ID Number \_\_\_\_\_

**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.

**AUTHORIZATION**

▶ Enrollee's Signature (Required) \_\_\_\_\_ Date \_\_ / \_\_ / \_\_\_\_

**AGENCY INFORMATION**

▶ Print HBA Name \_\_\_\_\_ HBA Phone Number (    ) \_\_\_\_\_

▶ HBA Signature (Required) \_\_\_\_\_ Date \_\_ / \_\_ / \_\_\_\_

**Keep this completed form as documentation of your State service and sick leave credit.**