STATE OF NEW YORK
DEPARTMENT OF CIVIL SERVICE
ALBANY, NEW YORK 12239

EMPLOYEE BENEFITS DIVISION

HEALTH INSURANCE TRANSACTION TRANSMITTAL FORM FOR PARTICIPATING AGENCIES

PS-516 (5/06)

Number of Transaction Forms Enclosed

Transmittal Date

Mo. Day Yr.

Agency Code

(2) PA 0

Agency Name If new address, check box ☐
Agency Address
Submitted by: Name
Title
Telephone No. (Include area code) ( )

IMPORTANT

The accuracy of your agency name, code and address is vital to the processing of health insurance enrollment data for your employees.

Transactions will process only if the agency code above matches the code at the centralized computer file. Recaps and other health insurance information will reach your agency only if the address maintained at the centralized computer file is up to date and accurate.

If there is a change in your agency mailing address, enter the new address on this form, check the new address box and circle the address in red.