



Please enter your personal information below and select an option to continue, convert or cancel life insurance coverage after retirement. If no election is made, your coverage will automatically continue into retirement. For more information about your options refer to your M/C Life Booklet or contact your agency's health benefits administrator.

ENROLLEE INFORMATION

Last Name First Name MI
Street Address Street City State Zip
Social Security Number ___ - ___ - ____
Telephone Number ()

ENROLLEE CONTINUATION/CONVERSION/CANCELLATION OF LIFE INSURANCE COVERAGE

You must decide if you wish to continue M/C Life Insurance, convert to a direct pay policy with Metropolitan Life Insurance Company or cancel coverage at this time. Please read instructions carefully and choose from one of the options below.

[] Option 1 - Continue M/C Life Insurance Coverage (Automatic, if no election is made)

Please continue my coverage into retirement. I understand that I will receive an initial billing amount and that monthly payments are due by the 1st day of each month. I understand my coverage will be subject to the agreed upon age reductions as a retiree. I understand that if my account becomes past due, my coverage will be cancelled and cannot be reinstated.

[] Option 2 - Full Conversion of M/C Life Insurance Coverage

I currently plan to exercise my conversion privileges. I am requesting Conversion Form G-685NY. I understand my M/C Life Group Coverage will be canceled. If I change my decision to exercise the conversion option, I know that I have 45 days from the date of my last paycheck to make a full monthly payment to the NYS Department of Civil Service with my request to remain in the M/C Life Insurance program.

[] Option 3 - Partial Conversion of M/C Life Insurance Coverage

I currently plan to exercise my conversion privileges for the reduction of coverage only, due to my age upon retirement. I am requesting a Conversion Form G-685NY.

[] Option 4 - Cancellation of M/C Life Insurance Coverage

Please cancel my coverage. I do not wish to continue my life insurance coverage during retirement. I understand that once my coverage is canceled, it cannot be reinstated.

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

The information you provide on this application is requested in accordance with Section 163 of New York State Civil Service Law for the principal purpose of administering the New York State Health Insurance Program. 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.

Signature _____ Date ___/___/_____

Once you've made your selection and signed and dated this form, return it to your agency's health benefits administrator no later than the date of your retirement. If you wish to submit a change in beneficiary or coverage, request the appropriate form from your agency. Complete the form and return it to your health benefits administrator.

AGENCY USE ONLY

Agency Code	Agency Name	
Retirement Date	Last Day Worked	Last Check Date

► Authorized Agency Signature (Required) _____ Date __ / __ / ____
Title _____ Telephone Number () _____

Retain one copy of this form for the enrollee and one copy of this form for Agency Records

Once you have reviewed the form to make sure it was filled out correctly and signed and dated by the enrollee, **return the completed form to:**

Employee Benefits Division
M/C Life Insurance Unit
NYS Department of Civil Service
Albany, NY 12239

If you have any questions about this procedure write the NYS Department of Civil Service, or call (518) 473-3496.