



1-12 EMPLOYEE INFORMATION

1. Last Name _____ First Name _____ MI _____

2. Social Security Number ____ - ____ - _____ 3. Gender F M X

4. Date of Birth __ / __ / _____ 5. Telephone Primary () _____ Work () _____

6. Non-smoker Smoker (Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the last 12 months)

7. Street Address Street _____ City _____ State _____ Zip _____

8. Department or Agency _____ 9. Agency Code _____

10. Negotiating Unit _____ 11. Annual Salary _____

12 CHOOSE ONE

New Application Late Application Declination of Coverage Other _____

Must also submit a PS-943.1 Beneficiary Designation Form with any new enrollment.

Change in Coverage – Reason _____ Effective Date __ / __ / _____

Any Increase in coverage will not be effective until proof of insurability is accepted by the insurance carrier.

For new application or change in coverage, one block must be checked in section 13.

13 COVERAGE OPTIONS

13A. Personal Life Insurance and Accidental Death & Dismemberment Insurance

\$5,000 \$10,000 \$15,000

One Times Salary* Two Times Salary* Three Times Salary* Four Times Salary* Five Times Salary*

Cancel Coverage

** Total amount rounded to the next higher \$1,000 if not an even \$1,000*

13B. Dependent Life Insurance Enter dependent information in Box 14.

Spouse and Children Spouse Only Children Only

Cancel Spouse Coverage Cancel Children Coverage

This coverage is not available unless the employee also has personal life insurance.

14 DEPENDENT INFORMATION

Last Name _____	First Name _____	MI _____	Relationship _____
Date of Birth __ / __ / _____	Gender <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X	Social Security Number ____ - ____ - _____	
Address (if different) Street _____		City _____	State _____ Zip _____

Last Name _____	First Name _____	MI _____	Relationship _____
Date of Birth __ / __ / _____	Gender <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X	Social Security Number ____ - ____ - _____	
Address (if different) Street _____		City _____	State _____ Zip _____

Last Name _____	First Name _____	MI _____	Relationship _____
Date of Birth __ / __ / _____	Gender <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X	Social Security Number ____ - ____ - _____	
Address (if different) Street _____		City _____	State _____ Zip _____

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.

15 ATTESTATION

I hereby apply for the group life insurance coverage indicated above and rescind any previous application for group life insurance offered by the State of New York to Managerial/Confidential employees and other eligible employees. I have completed the PS 934.1, *Beneficiary Designation Form*. I have received and read a copy of the current announcement describing such insurance. I hereby authorize you to deduct from my salary or retirement allowance the entire cost of premium or subscription charges for coverage under the group insurance plan for Managerial/Confidential employees authorized by the provisions of Section 158 of the Civil Service Law and to transmit the sums so deducted to the company carrying such insurance. You are further authorized to make any necessary changes or adjustments in said deductions as may be necessary from time to time because of changes in my rate or rates or in my coverage. This authorization shall be effective until revoked by me by written notice.

For a late application or an increase in coverage, please select; I have received the Statement of Health Yes No

► Signature _____ Date __ / __ / ____

Attach the *Beneficiary Designation Form (PS-934.1)* when you submit this application.

EMPLOYING AGENCY USE

Enter the following dates below:

Date of most recent appointment to M/C title __ / __ / ____

Date application received __ / __ / ____

If late enrollee, date approved by insurance carrier __ / __ / ____

Effective date of coverage or coverage change __ / __ / ____

I hereby certify that I have personally verified the salary, age and eligibility of the above applicant and provided a Statement of Health form if the enrollee responded yes in Box 15.

Printed Name _____ Title _____

► Signature _____ Date __ / __ / ____

DEPARTMENT OF CIVIL SERVICE USE

Printed Name _____ Title _____

► Signature _____ Date __ / __ / ____