NEW YORK STATE OF OPPORTUNITY. **Department of Civil Service**

**EMPLOYEE BENEFITS DIVISION**
M/C Life Insurance Transaction Form
Group #23900
PS-934 (1/2023)

## EMPLOYEE INFORMATION

| **1.** Last Name | First Name | MI | **2.** Social Security Number | **3.** Gender ☐F ☐M ☐X |
|---|---|---|---|---|
| **4.** Date of Birth | **5.** Telephone Number: ( ) | | **6.** ☐ Non-Smoker ☐ Smoker Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months | |
| **7.** Street Address | | | City State Zip Code | |

| **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 PS934.1 Beneficiary 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

**A. 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 next higher $1,000 if not an even $1,000

**B. Dependent Life Insurance**
**Enter dependent information in box 14**

- ☐ Spouse Only
- ☐ Spouse and Children
- ☐ Children Only
- ☐ Cancel Spouse Coverage
- ☐ Cancel Dependent 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 | Address *(if different)* | Social Security Number |
|---|---|---|---|---|---|---|---|
| | | | | | ☐F ☐M ☐X | | |
| | | | | | ☐F ☐M ☐X | | |
| | | | | | ☐F ☐M ☐X | | |

## 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, Designation of Beneficiaries 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.**

## 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.

### EMPLOYING AGENCY USE

**Enter the following dates below:**

- **Date first eligible for Managerial/Confidential Coverage** _____
- **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.**

**Print Name:** _____

**Title:** _____

**Signature:** _____ **Date:** _____

### DEPARTMENT OF CIVIL SERVICE USE

**Approved by**

**Print Name:** _____

**Title:** _____

**Signature:** _____ **Date:** _____