



EMPLOYEE INFORMATION

1. Last Name		First Name		MI	2. Social Security Number		3. Gender <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X	
4. Date of Birth		5. Telephone Number: ()			6. <input type="checkbox"/> Non-Smoker <input type="checkbox"/> 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

<p>A. Personal Life Insurance and Accidental Death & Dismemberment Insurance</p> <p><input type="checkbox"/> \$ 5,000 <input type="checkbox"/> Three Times Salary*</p> <p><input type="checkbox"/> \$10,000 <input type="checkbox"/> Four Times Salary*</p> <p><input type="checkbox"/> \$15,000 <input type="checkbox"/> Five Times Salary*</p> <p><input type="checkbox"/> One Times Salary <input type="checkbox"/> Cancel Coverage</p> <p><input type="checkbox"/> Two Times Salary*</p> <p>* Total amount rounded to next higher \$1,000 if not an even \$1,000</p>	<p>B. Dependent Life Insurance Enter dependent information in box 14</p> <p><input type="checkbox"/> Spouse Only</p> <p><input type="checkbox"/> Spouse and Children</p> <p><input type="checkbox"/> Children Only</p> <p><input type="checkbox"/> Cancel Spouse Coverage</p> <p><input type="checkbox"/> Cancel Dependent Coverage</p> <p>This coverage is not available unless the employee also has personal life insurance.</p>
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14. DEPENDENT INFORMATION

Last Name	First Name	MI	Relationship	Date of Birth	Gender	Address (if different)	Social Security Number
					<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X		
					<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X		
					<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> 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 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.

Print Name: _____

Title: _____

Signature: _____

Date: _____

DEPARTMENT OF CIVIL SERVICE USE

Approved by

Print Name: _____

Title: _____

Signature: _____

Date: _____