State of New York
Department of Civil Service
The State Campus
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

INSTRUCTIONS FOR THE PS-404
NYS HEALTH INSURANCE TRANSACTION FORM

PS-404 I (1/01)

Boxes 1 - 9	All enrollees must complete boxes 1 – 9 with their personal information. Note: Marital Status Date is used to show date of marriage, separation or divorce when those marital statuses are selected.

Box 10 (A – I)	Complete appropriate sections. The employee is entitled to make separate choices regarding their medical, dental and vision coverages. They may decline any of the three, all of the three, or none of the three different coverage options. Also, they many enroll in family coverage in one benefit and individual coverage in another. Reminder: Enrollees with a Benefit Fund (CSEA, UUP and DC-37) receive their dental and vision benefits through that Fund. **Do not** enter dental and vision information on NYBEAS for these enrollees.

New Enrollees (also complete 10.G for family coverage)

Note: for new enrollments in a Health Maintenance Organization (HMO), complete an HMO form in addition to this form.

10.A	Request Enrollment – Individual	Check box to enroll in individual coverage. Check Medical, Dental and/or Vision boxes for coverage being enrolled.
10.B	Request Enrollment – Family	Check box to enroll in family coverage. Check Medical, Dental and/or Vision boxes for coverage being enrolled.
10.C	Elect Pre-Tax Status?	New Enrollees choose to enroll in or decline the Pre-Tax Contribution Program for medical coverage.
10.D	Decline Coverage	Check box to decline coverage. Check Medical, Dental and/or Vision boxes for coverage being declined.

Cancellation or Change in Coverage

10.E	Voluntarily Cancel Coverage	The enrollee is entitled to make separate decisions regarding their medical, dental and vision coverages. Enrollees may cancel or change their dental and/or vision coverage(s) at any time during the year. Pre-tax medical enrollees may only cancel coverage during the Pre-Tax Open Enrollment Period, or with a qualifying event (enter the qualifying event). If you are going on **Leave Without Pay, also complete Box 12.**
10.F	Change Coverage	Check this box to change from Individual to Family, or from Family to Individual coverage. Pre-tax medical enrollees may only change their coverage from Family to Individual during the Pre-Tax Open Enrollment Period, or with a qualifying event (check the qualifying event and enter the Date of Event). Check Medical, Dental, and/or Vision boxes for coverage being changed.
10.G	Add/Change/Delete Dependents	Check the box to add or delete dependents or to change dependent information. Check Medical, Dental, and/or Vision boxes that apply. Complete all dependent information including **date of birth**. Additional documentation may be required to add the dependent.
10.H	Change Medical Benefit Plan	Complete during annual Option Transfer Period or with a qualifying event (for example, change of address outside of HMO area.)
10.I	Change Pre-Tax Status	Existing enrollees can only change pre-tax status during the annual Pre-Tax Open Enrollment Period in November.

Box 11	Complete previous coverage information, if applicable.

Box 12	LEAVE WITHOUT PAY SECTION	Enrollees going on leave without pay who request cancellation of coverage at the time they leave the payroll must complete this section. To request permanent cancellation of coverage, check the appropriate box and cross out the sentence which reads "I wish to resume my coverage upon return to the payroll."
	RETIREMENT SECTION	Enrollees leaving the payroll due to retirement must complete this section to indicate their decision to either defer or continue health insurance coverage as a retiree. A PS-406.2 must be completed for enrollees requesting deferment of medical coverage, prior to retirement.

Box 13	Request for Empire Plan Cards Only – complete this section to order a duplicate or replacement Benefit Card. **Do not** complete this section if requesting a change to your health insurance coverage. A new card will be issued automatically.

AUTHORIZATION	Employees must SIGN and DATE this form.

AGENCY/EBD USE ONLY	This section is for Agency and/or EBD use only and is provided to assist in updating the enrollee's record on NYBEAS.
Action/Reason	Transaction that will be inputted into NYBEAS by HBA.
Date of Event	Date the event took place, which resulted in the enrollee requesting a change to benefits. Example: first day worked, first day on leave, date of birth, date of marriage.
Hire Date	Original date of hire or rehire. (Only needed for new enrollment).
Date of 1st Eligibility (PE only)	The first day the enrollee is eligible for coverage.
Percentage Working	Enrollee's percentage on payroll.
Agency Code	Enrollee's agency code.
Neg. Unit	Enrollee's negotiating unit.
Ret. System	The retirement system for the enrollee (ERS, TRS or PFS)
Retirement Tier	Tier 1, 2, 3 or 4.
Sick Leave Information - # Hours	Number of sick leave hours for enrollee at time of retirement.
Sick Leave Information - Hourly Rate of Pay	Enrollee's hourly rate of pay based on annual salary at the time of retirement. (See Hourly Rate Calculation memo NY99-22).
Date Entered on NYBEAS	Date HBA processes the transaction on NYBEAS.
Effective Date	The effective date assigned to the transaction by NYBEAS.

Note: When updating NYBEAS, use **Date** in **Authorization Box** as **Date of Request**.

SUMMARY OF DOCUMENTATION THAT NEEDS TO BE SUBMITTED WITH COMPLETED PS-404

Employees	**Spouse/Domestic Partner**	**Children**
Copy of Birth Certificate	Copy of Birth Certificate	Copy of Birth Certificate
Copy of Social Security Card	Copy of Social Security Card	Copy of Social Security Card
	Copy of Marriage Certificate or Complete PS-425 series Domestic Partner, if Applicable	Completed PS-451 – Statement of Disability and Required Documentation, if Applicable
	For Changes of Coverage, copy of Marriage Certificate, Divorce Order, Death Certificate, PS-425.4 (Domestic Partner), as appropriate	Completed PS-457 – Statement of Dependence and Required Documentation, if Applicable