

11. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW

Change NYSHIP Option Change to: Empire Plan HMO Code HMO Name _____ Opt-out

Change Pre-Tax Status Change to: Pre-Tax Post-Tax Submit during the Pre-Tax Contribution Selection Period (November 1-30)

12. LEAVE WITHOUT PAY AND RETIREMENT STATUS

LEAVE WITHOUT PAY I wish to continue coverage while I am on authorized leave. Medical Dental Vision
I understand that I will be billed and must pay for this coverage.

I do not wish to continue coverage while I am on authorized leave. Medical Dental Vision
I wish to resume my coverage upon return to the payroll.

RETIREMENT I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage.

I understand the requirements for continuing medical insurance coverage as a retiree and wish to defer my coverage. (*A completed PS-406.2 must be attached.*)

I understand that I will receive an application for COBRA continuation of Dental and/or Vision coverage automatically.

Personal Privacy Protection Law Notification

The information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. 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 of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 457-9375. For information related to the Health Insurance Program, **contact your Agency Health Benefits Administrator**. If, after calling your Agency Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 4:00 p.m.

AUTHORIZATION

I have read the Pre-Tax Contribution Program materials and the Opt-out Attestation Form (if applicable), and have made my selection on Page 1 of this document. I understand that if my coverage is declined or canceled, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date and may forfeit the right to such coverage after leaving State service (vest, retirement, etc.). I am aware of how to obtain a current *Summary of Benefits and Coverage* for the NYSHIP option I have selected. I understand that my failure to provide required proof(s) within 28 days (30 days for newborns) may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims. **I certify that the information I have supplied is true and correct. I hereby authorize deduction from my salary or retirement allowance of the amount required, if any, for the coverage indicated above.**

Employee Signature (Required): _____ **Date:** _____

AGENCY/EBD USE ONLY

| Action/Reason | Date of Event | Hire Date | Date of 1 st Eligibility | Percentage Working | Agency Code | Neg. Unit | Ret. System |
|---------------|---------------|-----------|-------------------------------------|--------------------|-------------|-----------|-------------|
| | | | | | | | |

| Retirement Tier | Registration # | Sick Leave Information | | Date Entered on NYBEAS | Effective Date |
|-----------------|----------------|------------------------|--------------------|------------------------|----------------|
| | | # Hours | Hourly Rate of Pay | | |
| | | | | | |

HBA Signature (Required): _____ **Date:** _____



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

EMPLOYEE BENEFITS DIVISION
INSTRUCTIONS for PS-404
NYS HEALTH INSURANCE TRANSACTION FORM

Boxes 1 – 9

You must complete boxes 1 – 9 with your personal information.

Note: Use the Marital Status Date to show the date of marriage, separation or divorce when those marital statuses are selected.

Box 10 (A – G)

Complete appropriate sections. You are entitled to make separate choices regarding your medical, dental and vision coverage. You may enroll in or decline any of the three, all of the three, or none of the three different coverage options. Also, you may enroll for family coverage in one benefit and individual coverage in another.

Reminder: Enrollees with a Benefit Fund (CSEA, DC-37, UCS and UUP) receive their dental and vision benefits through that fund. If you are a member of one of these groups, you may not enroll for NYSHIP dental or vision benefits.

NEW ENROLLEES (also complete 10.G for family coverage)

Note: If you choose a NYSHIP HMO, the HMO may require you to complete an additional information form for New York State employees.

| | | |
|------|--|--|
| 10.A | Request Enrollment – Individual | Check box to enroll in individual coverage. Check Medical, Dental and/or Vision boxes for coverage selected. |
| 10.B | Request Enrollment – Family | Check box to enroll in family coverage. Check Medical, Dental and/or Vision boxes for coverage selected. |
| 10.C | Pre-Tax Contribution Program (PTCP) Status | New enrollees must make an election (Pre-Tax or Post-Tax) for the PTCP for medical coverage. |
| 10.D | Elect Opt-out Program Coverage (if eligible) | Check box to enroll in the Opt-out Program. Also complete PS-409, Opt-out Attestation form. |
| 10.E | Decline NYSHIP Coverage | Check box to decline coverage. Be sure to check the appropriate boxes for the coverage type declined. |

CANCELLATION OR CHANGE IN COVERAGE

| | | |
|------|------------------------------|--|
| 10.F | Voluntarily Cancel Coverage | You are entitled to make separate decisions regarding your medical, dental and vision coverage. You may cancel or change your dental and/or vision coverage(s) at any time during the year. If you are enrolled in pre-tax, you 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.G | Change Coverage | Check this box to change from Individual to Family or from Family to Individual coverage. If you are enrolled in pre-tax, you may only change coverage from Family to Individual during the pre-tax open enrollment period, or with a PTCP 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. |



State of New York
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Albany, NY 12239

EMPLOYEE BENEFITS DIVISION
INSTRUCTIONS for PS-404
NYS HEALTH INSURANCE TRANSACTION FORM

| | | |
|---------------|-----------------------------------|--|
| Box 11 | ANNUAL OPTION TRANSFER REQUEST(S) | Change NYSHIP Option: Complete during annual Option Transfer Period or with a qualifying event (for example, change of address outside of HMO area.) Change Pre-Tax Status: Existing enrollees can only change pre-tax status during the annual Pre-Tax Open Enrollment Period in November. |
| Box 12 | LEAVE WITHOUT PAY | You must complete this section if you are going on leave without pay and want to cancel coverage when you leave the payroll. |
| | RETIREMENT | You must complete this section if you are leaving the payroll due to retirement to indicate your decision to continue or defer your health coverage as a retiree. Also complete PS-406.2, Deferred Health Insurance for Retirees (Indefinitely) if you request deferment. Check the box to acknowledge that Dental and/or Vision coverage is available under COBRA, if applicable. |

| | |
|----------------------|-----------------------------------|
| AUTHORIZATION | You 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 with updating the enrollee's record on NYBEAS. |
| Action/Reason | Transaction that HBA will enter in NYBEAS. |
| Date of Event | Event date that 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 1 st Eligibility | 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 PFRS) |
| Retirement Tier | Tier 1, 2, 3, 4, 5 or 6. |
| 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. |
| 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**.

EXAMPLES OF DOCUMENTATION REQUIRED TO PROCESS YOUR TRANSACTION

| Employee | 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, Domestic Partner series, 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 |