



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

EMPLOYEE BENEFITS DIVISION
NYS HEALTH INSURANCE TRANSACTION FORM
For Participating Employers PS-404 PE (8/02L)

INSTRUCTIONS: READ AND COMPLETE BOTH SIDES/PAGES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.

EMPLOYEE INFORMATION

(All employees must complete)

1. Last Name		First Name	MI	2. Social Security Number	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
4. Street Address		City		State	Zip
5. Date of Birth	6. Telephone Numbers Home () Work ()			7. Work location and address	
8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Marital Status Date				
9. Covered under Medicare? Self <input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse/Domestic Partner/Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No			

10. ENTER REQUEST(S) BELOW

A. <input type="checkbox"/> Request Enrollment- Individual	<i>(Select Empire Plan or HMO)</i> <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO* Code <input type="text"/> Name	
B. <input type="checkbox"/> Request Enrollment- Family (Complete G)	<i>(Select Empire Plan or HMO)</i> <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO* Code <input type="text"/> Name	
C. <input type="checkbox"/> Elect Pre-Tax Status for Premium deduction?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Note: pretax deductions may not be offered by all agencies. Verify eligibility with your agency.
D. <input type="checkbox"/> Decline Coverage	<i>For Agency Use: (Process WAV/BEN transaction)</i>	
E. <input type="checkbox"/> Voluntarily Cancel Coverage		

F. <input type="checkbox"/> Change Coverage	Date of Event _____	
<input type="checkbox"/> Change to FAMILY (Complete G) <ul style="list-style-type: none"> <input type="checkbox"/> Marriage <input type="checkbox"/> Domestic Partner <input type="checkbox"/> First dependent child acquired <input type="checkbox"/> Dependent returned to full-time student status <input type="checkbox"/> Request coverage for dependents not previously covered <input type="checkbox"/> Newborn <input type="checkbox"/> Previous coverage terminated (Complete Section 11) <input type="checkbox"/> Other _____ 		<input type="checkbox"/> Change to INDIVIDUAL <ul style="list-style-type: none"> <input type="checkbox"/> I voluntarily cancel coverage for my dependents <input type="checkbox"/> I voluntarily cancel coverage for my domestic partner <input type="checkbox"/> Only dependent died <input type="checkbox"/> Only dependent married <input type="checkbox"/> Only dependent graduated <input type="checkbox"/> Divorce <input type="checkbox"/> Only dependent disqualified by age <input type="checkbox"/> Termination of domestic partnership (Attach Completed PS-428.4) <input type="checkbox"/> Other _____

G. DEPENDENT INFORMATION *(use additional sheets if necessary)*

Check One: A (Add), D (Delete) or C (Change)		Date of Event _____						
	Last Name	First Name	MI	Relationship	Date of Birth	Sex	Address (if different)	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C								
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C								
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C								
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C								
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C								

* A completed HMO form must be attached.

10. Continued. ENTER REQUEST(S) BELOW

H. Change Medical Benefit Plan Change to: Empire Plan HMO * Code HMO Name _____
* A completed HMO form must be attached.

11. PREVIOUS COVERAGE INFORMATION

If you were previously covered under NYSHIP or another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.	Previous ID Number	Date Coverage Terminated
	Enrollee's Name Under Which Previously Covered	Last First Middle Initial

12. LEAVE WITHOUT PAY AND RETIREMENT STATUS

LEAVE WITHOUT PAY

I wish to continue coverage while I am on authorized leave. I understand that I will be billed for this coverage.

I do not wish to continue coverage while I am on authorized leave. 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.)

13. REQUEST FOR EMPIRE PLAN CARD ONLY

For Health Maintenance Organization (HMO) cards, contact your HMO.

DUPLICATE CARD (Previously issued card remains valid.)

REPLACEMENT CARD (Previously issued card(s), lost or stolen, become invalid.)

FOR

ENROLLEE

ENROLLEE AND ALL DEPENDENTS

INDIVIDUAL DEPENDENT

Name _____

Personal Privacy Protection Law Notification

This 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, The State Campus, 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 3:00 p.m.

AUTHORIZATION

I have read the Pre-Tax Contribution Program memorandum and have made my selection on Page 1 of this document, if applicable. I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving State service (vest, retirement, etc.). **I certify that the information I have supplied is true and correct.** 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 misstatement of fact or conceals any pertinent information, commits a crime which is subject to a \$5,000 penalty and the stated value of the claim for each violation. I hereby **authorize deduction from my salary or retirement allowance** of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

→ Employee's Signature (Required) _____ Signature Date (Required) _____

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: _____ **Date:** _____