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

EMPLOYEE BENEFITS DIVISION
NYS HEALTH INSURANCE TRANSACTION FORM
PS-404 (9/16)

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 last 4 digits

3. Sex ☐ Male ☐ Female

4. Street Address | City | State | Zip

5. Date of Birth

6. Telephone Numbers
Primary ( ) Work ( )

7. Work location and address
SUNY Buffalo State
1300 Elmwood Avenue
Buffalo, NY 14222

8. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated | Marital Status Date

9. Covered under Medicare? Self: ☐Yes ☐ No Spouse/Domestic Partner: ☐Yes ☐ No Child: ☐Yes ☐ No

10. DEPENDENT INFORMATION

Must be provided when choosing to enroll or opt-out of NYSHIP family coverage *(use additional sheets if necessary)*

Check One: A (Add), D (Delete) or C (Change)
Check all that apply: M (Medical), D (Dental), and V (Vision)
Date of Event _____

☐ A ☐ D ☐ C	☐ M ☐ D ☐ V	Last Name First Name MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security Number
☐ A ☐ D ☐ C	☐ M ☐ D ☐ V						
☐ A ☐ D ☐ C	☐ M ☐ D ☐ V						
☐ A ☐ D ☐ C	☐ M ☐ D ☐ V						
☐ A ☐ D ☐ C	☐ M ☐ D ☐ V						

11. NEW OR NEWLY ELIGIBLE EMPLOYEES: CHOOSE ONE OF THE FOLLOWING OPTIONS (A, B OR C)

A. Enroll in NYSHIP Coverage: Choose options 1 or 2 and complete box 3

1. **Individual Enrollment**	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code [ ] Name _____	☐ Dental *(11)*	☐ Vision *(14)*
2. **Family Enrollment** *(Complete box 10)*	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code [ ] Name _____	☐ Dental *(11)*	☐ Vision *(14)*

3. ☐ **Elect Pre-Tax Status** for Premium deduction ☐ **Elect Post-Tax Status** for Premium deduction
Please read the Pre-Tax Contribution program materials.

B. Elect the Opt-out program (if eligible): Complete boxes 1 and 2

1. ☐ **Individual Opt-out** ☐ **Family Opt-out** If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.

2. ☐ **Elect Pre-Tax Status** for Premium deduction ☐ **Elect Post-Tax Status** for Premium deduction
Please read the Pre-Tax Contribution program materials.

C. Decline NYSHIP Coverage ☐ Medical*(10)* ☐ Dental *(11)* ☐ Vision *(14)*

12. TO CHANGE OR CANCEL COVERAGE CHOOSE FROM THE BOXES BELOW

A. Change Coverage: ☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* **Date of Event:** _____

☐ **Change to FAMILY** *(Complete box 10)*
- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Dependent returned to full-time student status *(Dental and Vision only)*
- ☐ Other _____

☐ **Change to INDIVIDUAL**
- ☐ Divorce
- ☐ Termination of Domestic Partnership *(Attach completed PS-425.4)*
- ☐ Only dependent ineligible due to age
- ☐ I voluntarily cancel coverage for my dependents
- ☐ Only dependent died
- ☐ Only dependent married *(Dental and Vision only)*
- ☐ Only dependent graduated *(Dental and Vision only)*
- ☐ Other _____

B. Voluntarily Cancel Coverage: ☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* Qualifying Event:
NOTE: If you are enrolled in the Pre-Tax Contribution Program, your ability to make mid-year changes may be limited.

13.	ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW
Change NYSHIP Option	Change to: ☐ Empire Plan ☐ HMO Code ☐ HMO Name _____
Elect Opt-out (if eligible)	☐ Individual Opt-out ☐ Family Opt-out If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.
Change Pre-Tax Status	Change to: ☐ Pre-Tax ☐ Post-Tax Submit during the Pre-Tax Contribution Selection Period (November 1-30)

14. 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 and must pay for this coverage. ☐ Medical ☐ Dental ☐ Vision

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

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) 473-2624. For information related to the Health Insurance Program, **contact your Health Benefits Administrator**. If, after calling your 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 30 days 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 1st Eligibility	Percentage Working	Agency Code	Neg. Unit	Retirement System

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

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