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

EMPLOYEE BENEFITS DIVISION
HEALTH INSURANCE TRANSACTION FORM
FOR NYS & PE EMPLOYEES

PS-404 (9/19)

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 ☐ Male ☐ Female

4. Permanent Address Street | City | State | Zip

5. Mailing Address (If different) Street | City | State | Zip

6. Work Location & Address Street | City | State | Zip

7. Date of Birth

8. Telephone Numbers Primary ( ) Work ( )

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

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

11. ELECT OR DECLINE COVERAGE

A. Choose a Pre-Tax election

1. ☐ **Elect Pre-Tax Status** for Premium deduction **2.** ☐ **Elect After-Tax Status** for Premium deduction
You are only eligible for Pre-Tax deductions if newly eligible or if requested during the Pre-Tax Contribution Program (PTCP) Election Period

B. Select a NYSHIP Coverage Option (Choose option 1, 2, 3 or 4)

1. Individual Enrollment	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	☐ Dental *(11)*	☐ Vision *(14)*
2. Family Enrollment *(Complete box 13 on page 2)*	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	☐ Dental *(11)*	☐ Vision *(14)*
3. Opt-out Program *(NYS Medical only)*	☐ Individual Opt-out ☐ Family Opt-out (Complete Box 13) If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.	☐ Dental *(11)*	☐ Vision *(14)*
4. Decline Coverage	☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)*		

12. CHANGE OR CANCEL EXISTING COVERAGE

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

☐ **Change to FAMILY** *(Complete box 13)*

- ☐ 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: _____

NOTE: If you are indicating a change in marital status to Divorced or Separated, please be sure to update the address information for the dependent in Box 13 if applicable.

B. Voluntarily Cancel Coverage: ☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* Qualifying Event: _____

NOTE: If you are enrolled in the PTCP, you may make changes during the Annual Option Transfer Period or when experiencing a PTCP qualifying event.

13. 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: _____

		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								

14. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW

Change NYSHIP Option	Change to: ☐ Empire Plan ☐ HMO Code ☐	HMO Name: _____
Elect Opt-out *(NYS Medical only)*	☐ 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 ☐ After-Tax	Submit during the Pre-Tax Contribution Program Election Period

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. Eastern time.

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 USE ONLY

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

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

NYSHIP Program Information Resources

To enroll in benefits or to change your current benefits, you will most likely be required to submit proofs of eligibility for coverage or evidence of a qualifying event with the completed and signed *Health Insurance Transaction Form* PS-404. Learn more about these additional requirements in the following publications:

- ***General Information Book (GIB)***
  Eligibility, enrollment, required forms and proofs of eligibility
- ***Planning for Option Transfer***
  The Pre-Tax Contribution Program (PTCP)
- ***Choices***
  Your plan options under NYSHIP (Empire Plan, NYSHIP HMO or the Opt-out Program) and the benefits included with each one

In many situations, you will also be required to complete, sign and submit additional forms and proofs. For detailed instructions on what will be required, please refer to your *GIB* and any additional forms and form instructions for requirements specific to your request.

EMPLOYEE INFORMATION

Boxes 1 – 10	Employee Information	You must complete boxes 1 – 10 with your personal information. **Note:** Use the Marital Status Date to show the date of marriage, separation or divorce when any of those marital statuses are selected.
Boxes 11 (A-B)	Elect or Decline Coverage	Complete appropriate sections. You are entitled to make separate choices regarding your medical, dental and vision coverage. You may enroll in or decline any or all three. (**Exception:** Enrollment in the Student Employee Health Plan [SEHP] includes medical, dental, and vision coverage). You may also enroll in Family coverage for one benefit in Individual coverage for another. **Reminder:** Enrollees with an Employee 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.

ELECT OR DECLINE COVERAGE

Note: If you choose a NYSHIP HMO, the HMO may require you to complete an additional enrollment form.

11.A.1 11.A.2	Pre-Tax Contribution Program (PTCP) Status	New enrollees must make an election (Pre-Tax or After-Tax) for medical coverage. The PTCP applies to all NYS groups and select Participating Employers (PE). If you work for a PE, contact your HBA to learn if your employer participates in the PTCP and if you are eligible to enroll. If you are a new enrolling after your waiting period or more than 30 days after a qualifying event, you will need to wait until the annual PTCP Election Period to enroll. The PTCP Election Period coincides with the annual Option Transfer Period. Until then, your deductions will be taken out after taxes.
11.B.1	Individual Enrollment	Check box to enroll in Individual coverage. Check Medical, Dental and/or Vision boxes for coverage selected.
11.B.2	Family Enrollment	Check box to enroll in Family coverage. Check Medical, Dental and/or Vision boxes for coverage selected.
11.B.3	Elect the Opt-out Program (NYS Medical Only)	Check box to enroll in the Opt-out Program (See your HBA or your plan materials for eligibility requirements). Also complete PS-409, *Opt-out Attestation Form*.
11.B.4	Decline NYSHIP Coverage	Check box to decline coverage. Be sure to check the appropriate boxes for the coverage type declined.

CHANGE IN COVERAGE OR VOLUNTARILY CANCEL COVERAGE

Box 12.A	Change Coverage	Check this box to change from Individual to Family or from Family to Individual coverage. If you are enrolled in PTCP, you may only change coverage from Family to Individual during the annual Option Transfer Period, or within 30 days of 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. In the event that you are indicating a change in your marital status to divorced or separated, please update the dependent's new address, if applicable, in the Dependent Information section (Box 13).
Box 12.B	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 PTCP, you may only cancel coverage during the annual Option Transfer Period, or within 30 days of a PTCP qualifying event (enter the qualifying event).

DEPENDENT INFORMATION

Box 13	Dependent Information	Check the box to add or delete a dependent or to change a dependent's information. Check Medical, Dental and/or Vision boxes that apply. Complete all dependent information and provide the dependent's Social Security Number. Additional documentation is required to add the dependent.

ANNUAL OPTION TRANSFER REQUEST(S)

Box 14	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). **Elect Opt-out:** Enrollees electing the Opt-out Program must complete a PS-409, *Opt-out Attestation Form*. If you are selecting Family Opt-out, you must have been enrolled in NYSHIP Family coverage beginning April 1 of the current plan year. (See your HBA or your plan materials for additional eligibility requirements.) **Change Pre-Tax Status**: Existing enrollees can only change PTCP status during the annual PTCP Election Period, which coincides with the annual Option Transfer Period.

AUTHORIZATION	You must SIGN and DATE this form.