



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 (Only eligible for Pre-Tax deductions if newly eligible or if requested during the PTCP election period, Nov 1-30)
1. Elect Pre-Tax Status for Premium deduction 2. Elect After-Tax Status for Premium deduction
B. Select a NYSHIP Coverage Option (Choose option 1, 2, 3 or 4) (NOTE: HMO and Opt-out not available to CUNY)
1. Individual Enrollment Medical (10) (Select Empire Plan or HMO) Dental (11) Vision (14)
2. Family Enrollment (Complete box 13 on page 2) Medical (10) (Select Empire Plan or HMO) Dental (11) Vision (14)
3. Opt-out Program (NYS Medical only) Individual Opt-out Family Opt-out (Complete Box 13) 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) Change to INDIVIDUAL
Marriage Divorce
Domestic Partner Termination of Domestic Partnership (Attach completed PS-425.4)
Newborn Only dependent ineligible due to age
Request coverage for dependents not previously covered I voluntarily cancel coverage for my dependents
Previous coverage terminated (proof required) Only dependent died
Dependent returned to full-time student status (Dental and Vision only) Only dependent married (Dental and Vision only)
Other: 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 Pre-Tax Contribution Program, you may make changes during the Annual Option Transfer Period or when experiencing a qualifying event.

13. DEPENDENT INFORMATION								
<b>Must be provided when choosing to enroll or opt-out of NYSHIP family coverage (use additional sheets if necessary)</b>								
<b>Check One: A (Add), D (Delete) or C (Change)</b>						<b>Date of Event: _____</b>		
<b>Check all that apply: M (Medical), D (Dental), and V (Vision)</b>								
↓	↓	↓	↓	↓	↓	↓	↓	↓
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"/> M <input type="checkbox"/> D <input type="checkbox"/> V							
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V							
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V							
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V							

14. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW	
<b>Change NYSHIP Option</b>	Change to: <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code <input style="width: 40px;" type="text"/> HMO Name: _____
<b>Elect Opt-out</b> <i>(NYS Medical only)</i>	<input type="checkbox"/> Individual Opt-out <input type="checkbox"/> Family Opt-out <small>If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.</small>
<b>Change Pre-Tax Status</b>	Change to: <input type="checkbox"/> Pre-Tax <input type="checkbox"/> After-Tax <small>Submit during the Pre-Tax Contribution Selection Period (November 1-30)</small>

**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	
<p>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 <i>Summary of Benefits and Coverage</i> 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. <b>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.</b></p>	
<b>Employee Signature (Required):</b> _____	<b>Date:</b> _____

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

<b>HBA Signature (Required):</b> _____	<b>Date:</b> _____
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