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

EMPLOYEE BENEFITS DIVISION
NYS HEALTH INSURANCE TRANSACTION FORM

PS-404 (12/14)

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. Street Address City State Zip		
5. Date of Birth	**6.** Telephone Numbers Primary ( ) Work ( )	**7.** Work location and address
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. ENTER REQUEST(S) BELOW

A. ☐ Request Enrollment- **Individual**	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	☐ Dental *(11)*	☐ Vision *(14)*
B. ☐ Request Enrollment- **Family** (Complete G)	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	☐ Dental *(11)*	☐ Vision *(14)*
C. ☐ Elect Pre-Tax Status for Premium deduction ☐ Elect Post-Tax Status for Premium deduction Please read the Pre-Tax Contribution program materials.			
D. ☐ Elect Opt-out (if eligible)	If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.		
E. ☐ Decline NYSHIP Coverage (including Opt-out)	☐ Medical (including Opt-out) *(10)*	☐ Dental *(11)*	☐ Vision *(14)*
F. ☐ Voluntarily Cancel Coverage	☐ Medical *(10)* Qualifying Event:	☐ Dental *(11)*	☐ Vision *(14)*

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

☐ Change to FAMILY *(Complete G)*

- ☐ 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 enrolled in the Pre-Tax Contribution Program, your ability to make mid-year changes may be limited.

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 _____

Check One	Check all that apply	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. 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 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	Ret. System

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

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

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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 many 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.

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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 Date of 1st Eligibility	Original date of hire or rehire. (Only needed for new enrollment). The first day the enrollee is eligible for coverage.
Percentage Working	Enrollee's percentage on payroll.
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

Note: ALL employees and dependents must provide copies of his or her birth certificate and Social Security card

Spouse	**Domestic Partner**	**Children**
Copy of marriage certificate	Completed PS-425 (Domestic Partner series) and required documentation	Completed PS-457 (Statement of Dependence) and required documentation, if applicable
And for marriages dated more than one year prior, proof of current joint ownership/financial obligation	For changes of coverage, copy of death certificate, PS-425.4 (Domestic Partner) or death certificate	Completed PS-451 (Statement of Disability) and required documentation, if applicable
For changes of coverage, copy of marriage certificate, divorce order or death certificate		