AFTER CAREFUL REVIEW OF THIS COMPLETE PACKET, PLEASE CONTACT:

KATHY ZAZARINE
(518) 437-4730
KZAZARINE@ALBANY.EDU

FOR ASSISTANCE BEFORE SUBMITTING DOMESTIC PARTNERSHIP DOCUMENTS.

Paperwork will be reviewed by appointment only.

THANK YOU.

<u>Domestic Partnership Packets</u>

The following forms and documents are required when enrolling a domestic partner:

- ☐ A notarized PS-425 partnership application with the appropriate boxes checked on pages 1 **and** 3;
- ☐ Your domestic partner's Social Security number;
- ☐ A copy of your domestic partner's birth certificate (a passport can be accepted in lieu of a birth certificate)

Additionally, the following form and documents are required if you are newly enrolling, if you are enrolling your own eligible dependent children, and/or your domestic partner's eligible dependent children:

- ☐ A PS-404 or PS-404G (for Graduate/Teaching Assistants) NYS Health Insurance Transaction form;
- ☐ Social Security card for self and/or Social Security number(s) for all dependent children;
- ☐ Birth certificate(s) for self and/or all dependent children (a passport can be accepted in lieu of a birth certificate for self only)

*__Documentation rules state that, <u>from your application date:</u>__

Proof of Joint Responsibility:

- Proof #1 – Document must be at least 6 months old;
- Proof #2 – Document must be dated within 6 months of PS-425 application and cannot be same type of proof submitted as #1

Proof of Cohabitation:

- Poof #1 – Document must be at least 6 months old

<u>Note</u>: All supporting documentation must be in English or have an official English translation attached.

First type of Joint Responsibility documentation	Effective date(s) of documentation	Do the dates meet the requirements?
______________________	______________________	O Yes O No

Second type of Joint Responsibility documentation	Effective date(s) of documentation	Do the dates meet the requirements?
______________________	______________________	O Yes O No

Cohabitation document	Effective date(s) of documentation	Do the dates meet the requirements?
______________________	______________________	O Yes O No

If you answered yes to all three above, please call the Benefits Office at 437-4729 to schedule an appointment to submit your paperwork with the required forms and documentation.

If you answered no to any of the above, we will be unable to process your domestic partnership application. Please review the acceptable documents and date requirements.

Department of Civil Service

EMPLOYEE BENEFITS DIVISION
New York State Health Insurance Program (NYSHIP)
Domestic Partner Enrollment Application

PS-425 (3/17)

PLEASE READ PAGES 4-6 BEFORE YOU COMPLETE AND SUBMIT THIS APPLICATION.

EMPLOYEE INFORMATION		
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. I wish to add my Domestic Partner to: ☐ Medical ☐ Dental ☐ Vision		

DOMESTIC PARTNER INFORMATION				
9. Last Name First Name	Date of Birth	Sex	Social Security Number	
10. Domestic Partner 65 or Older: ☐ Yes ☐ No				
NOTE: Domestic Partners 65 or Older MUST be enrolled in Medicare Parts A and B to avoid a reduction of benefits				
11. Domestic Covered under Medicare: ☐ Yes ☐ No Medicare Claim Number: ____________________				

SECTION A

You and your Domestic Partner must be able to answer "YES" to all of the statements below and be able to provide the required documentation in order for your Domestic Partner to qualify for coverage under NYSHIP.

Yes

☐ We are each 18 years of age or older.

☐ We are not related in a manner that would bar marriage in New York State.

☐ I am not legally married to anyone else. If I am divorced, I am submitting a divorce decree for my prior marriage. Legal separation does not constitute a termination of marriage.

☐ My Domestic Partner is not legally married to anyone else. If he or she is divorced, I am submitting a divorce decree for his or her prior marriage. Legal separation does not constitute a termination of marriage.

☐ Neither I, nor my partner, have had a Domestic Partner enrolled in NYSHIP within the last year.

☐ We have shared the same residence for at least the last six months and have included proof of cohabitation as described in Section B of this form.

☐ We have had an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations for at least the last six months and we expect that commitment to last indefinitely. We included proof of joint responsibility for basic financial obligations as described in Section B of this form.

☐ I, the enrollee, understand that I am required to file a completed Form PS-425.4, Termination of Domestic Partnership, within 30 days of the date my domestic partnership ends or when I no longer can provide proof of one or more of the above requirements.

SECTION B

You are required to submit documentation as outlined below. In addition to providing proof of your eligibility for Domestic Partner coverage at the time of application, you are required to maintain the ability to provide proof of eligibility for as long as you wish to continue to cover your Domestic Partner as your dependent in NYSHIP. You may also be required to periodically provide proof of your Domestic Partner's eligibility. If at any time, you cannot provide proof of eligibility of your Domestic Partner as your dependent, then your partnership is no longer in effect and you must complete and submit Form PS-425.4, Termination of Domestic Partnership.

Your domestic partnership is considered to be in effect as of the earliest documented date that you and your Domestic Partner were both living together and financially interdependent. This date will be referred to as your "Partnership Establishment Date," and will be used to determine when your Domestic Partner may be enrolled in NYSHIP coverage. If you provide separate proofs of cohabitation and financial interdependence that are at least six months old, your domestic partnership will be considered established as of the date of the more recent of those proofs. All establishing proofs must verify your domestic partnership has been in place for a minimum of six months. Additionally, you will be required to provide a financial proof that is fewer than six months old to confirm the partnership is still in place.

Proof of Joint Responsibility for Basic Financial Obligations. You must submit two forms of proof from the list below. One of these proofs must be at least six months old on the date you submit this form. The second proof from this list must be dated within six months of the date you submit this form, and must be a different form of proof than the older proof submitted. For example, if you provide a statement from your joint bank account as your first form of proof, you may not provide a more recent statement from the same bank account as second form of proof.

Acceptable proofs are as follows:

- Joint mortgage or lease agreement
- Joint ownership of residence
- Joint wills or designation of the Domestic Partner as executor and/or primary beneficiary
- Designation of the Domestic Partner as beneficiary for life insurance or retirement benefits
- Designation of the Domestic Partner as durable power of attorney
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
- Joint obligation on a loan (may submit a creditor's affidavit for a personal loan)
- Joint ownership of a brokerage investment account
- Joint insurance policy (homeowners' or renters' policy)
- Joint ownership or lease of a motor vehicle
- Joint financial responsibility for child care (e.g., school tuition, guardianship)
- Joint household budget for the purpose of receiving government benefits
- Status as an authorized signatory on the partner's bank account, credit card or charge card
- Designation of one partner as the representative payee for the other's government benefit
- Joint bank, joint credit card or joint charge card account

Proofs such as a motor vehicle insurance policy listing the Domestic Partner as a driver or a phone bill listing the Domestic Partner as a user are not acceptable.

Proof of Cohabitation. You must submit at least one form of proof from the list below to prove that you and your Domestic Partner reside together. All documents submitted for proof of cohabitation must be at least six months old on the date you submit this form. This proof may be one document on which both names appear or two separate documents that specify each partner's residential address. Your proofs must contain a residential address. A P.O. Box is not an acceptable proof.

Acceptable proofs are as follows:

- Bank statement mailed to residential address
- Pay check stub
- Driver's license or automobile registration showing residential address
- Insurance benefits statement mailed to residential address
- Joint membership statement mailed to residential address (e.g., church or other organization)
- Joint mortgage or lease agreement
- Joint ownership of residence
- Tax return listing residential address
- Telephone/Utility bill mailed to residential address
- Registration as a domestic partnership in a New York State municipality that has established such a procedure

SECTION C

The citation below from the Internal Revenue Code (IRC) may be helpful in determining if your Domestic Partner is a federally qualified dependent for tax purposes. **It is recommended that you seek the advice of a tax professional before you complete this affidavit**.

According to IRC Section 152 (d)(1)(c), the Domestic Partner of a NYSHIP enrollee may be considered a federally qualified dependent if the NYSHIP enrollee "provides over one-half of the individual's support for the calendar year." A Domestic Partner must also reside in the same household as the enrollee in order to be considered a federally qualified dependent.

____

Name of Dependent   Social Security Number

☐ DOES fully qualify as my dependent under Internal Revenue Code Section 152. Checking this box is my official affirmation to NYSHIP that **I am not subject to federal tax withholding for** any imputed income resulting from benefits extended to my Domestic Partner. I understand that I will be required to complete Form PS-425.3, Dependent Tax Affidavit, if my Domestic Partner's status under IRC Section 152 changes at any time.

☐ DOES NOT qualify as my dependent under Internal Revenue Code Section 152. Checking this box is my official affirmation to NYSHIP that **I am responsible for reporting and paying federal tax** on any imputed income resulting from benefits extended to my Domestic Partner. I understand that if I am enrolled in the Pre-Tax Contribution Program, that the dependent portion of the cost of my NYSHIP family coverage will be taken on a post-tax basis because my dependent is not federally qualified. I understand that I will be required to complete PS-425.3, Dependent Tax Affidavit, if my dependent's status under IRC Section 152 changes at any time.

Personal Privacy Protection Law Notification

The information you provide on this application is requested for the principal purpose of administering the New York State Health Insurance Program, Dental Program, Vision Program, and/or Employee Benefit Fund Program. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law. Failure to provide the information requested may prevent the Department from processing this application. This information will be maintained by the Employee Benefits Division, NYS Dept. of Civil Service, Albany, NY 12239. For information related to the Personal Privacy Protection Law, call (518) 457-9375. **For more information concerning the Domestic Partnership Program, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 4:00 p.m.**

I, the enrollee, and my Domestic Partner, understand that any false or misleading statements made in Sections A, B or C of this NYSHIP Domestic Partner Enrollment Application will subject me to financial responsibility for any benefits paid on behalf of my partner and/or my partner's children. I understand that false statements may result in disciplinary action by my employer and/or result in criminal and/or civil penalties and in other legal actions such as the prosecution of insurance fraud.

Print Name (Enrollee): ____

Enrollee Signature: ____ ____________________
(sign in the presence of notary)
Date

Print Name (Domestic Partner): ____

Domestic Partner; ____ ____________________
(sign in the presence of notary)
Date

Subscribed and sworn to before me on this _____day of _________________, __________

NOTARY PUBLIC: ____

Department of Civil Service

EMPLOYEE BENEFITS DIVISION
Instructions for NYSHIP
Domestic Partner Enrollment Application

The following information pertains to enrollment under the New York State Health Insurance Program (NYSHIP) for Domestic Partners of individuals enrolled through New York State.

How to Apply

Submit the following items to the appropriate office:

- Form PS-425, Domestic Partner Enrollment Application, with supporting documentation as noted on the form.
- Photocopy of your Domestic Partner's Birth Certificate;
- Your Domestic Partner's Social Security Number;
- Your Domestic Partner's Medicare Claim Number and enrollment dates (if applicable); and
- Photocopy of your and/or your Domestic Partner's divorce decree (if applicable).

You must submit Form PS-404, in addition to this application, if you wish to add any of your Domestic Partner's children to your NYSHIP coverage.

Applications filed without all of these items will not be processed. If all required documentation is not submitted within 30 days of the signed Form PS-425, it will not be accepted. A new Form PS-425 will need to be completed, and the later signed request will be used as the date of request.

For Active Employees: Submit the required forms and proofs to your agency HBA.

For Retirees: Submit the required forms and proofs to the New York State Department of Civil Service, Employee Benefits Division, Albany, NY 12239.

Section A – Domestic Partner Eligibility Requirements

You and your Domestic Partner must affirm "Yes" to each of the statements listed in Section A in order for your Domestic Partner to qualify for coverage under NYSHIP. If you cannot affirm "Yes" to each statement, your Domestic Partner is not eligible for coverage under NYSHIP.

Section B – Required Proofs

To cover your Domestic Partner in NYSHIP, you must submit proof of joint responsibility for basic financial obligations and proof of cohabitation.

For proof of joint responsibility for basic financial obligations, you must submit two documents from the list included on Form PS-425. One of these proofs must be at least six months old on the date you submit your PS-425. The second proof from this list must be dated within six months of the date that you submit your PS-425, and must be a different form of proof than the older proof submitted. For example, if you provide a statement from your joint bank account as your first form of proof, you may not provide a more recent statement from that same bank account as the second form of proof.

For proof of cohabitation, you must submit at least one document from the list included on Form PS-425. You may submit one document on which both names appear or two separate documents that specify each partner's residential address. Proofs of cohabitation must contain a residential address, not a PO Box. All documents submitted for proof of cohabitation must be at least six months old on the date you submit your PS-425.

Your domestic partnership is considered to be in effect as of the earliest documented date that you and your Domestic Partner were both living together and financially interdependent. This date will be referred to as your "Partnership Establishment Date," and will be used to determine when your Domestic Partner may be enrolled in NYSHIP coverage. If you provide separate proofs of cohabitation and financial interdependence that are at least six months old, your domestic partnership will be considered established as of the date of the more

recent of those proofs. All establishing proofs must verify your domestic partnership has been in place for a minimum of six months. Additionally, you will be required to provide a financial proof that is fewer than six months old to confirm the partnership is still in place.

Section C – Federally Qualified Dependent Status and Pre-Tax Contribution Program (PTCP)

Federally Qualified Dependent Status

When enrolling a Domestic Partner, you must state whether he or she is your federally qualified dependent. The federal Internal Revenue Code (IRC) includes criteria that determine whether your Domestic Partner should be considered a federally qualified dependent. You should consult your tax advisor if you have questions as to whether your Domestic Partner is a federally qualified dependent or if you have questions regarding the effect of these requirements on your taxes. It is important you correctly report your Domestic Partner's status, as incorrect reporting can have serious negative tax implications.

If your Domestic Partner is a federally qualified dependent, check the first box in Section C.

If your Domestic Partner is not a federally qualified dependent, check the second box in Section C. In this case the fair market value of your Domestic Partner's coverage, referred to as imputed income, is considered to be a taxable fringe benefit. The State is required to calculate and report imputed income to the Internal Revenue Service (IRS) for its enrollees who provide NYSHIP coverage for non-federally qualified Domestic Partners. The imputed income will increase your taxable gross income for federal and state income taxes, as well as Social Security and Medicare payroll taxes. Refer to the appropriate group below for information on how imputed income is handled for State enrollees:

- **For Active Employees** covering a non-federally qualified dependent, a biweekly imputed income amount will be reported to the New York State Office of the State Comptroller for each payroll period. This amount is considered to be additional income for tax purposes only. Additional withholding taxes will be calculated and withheld based upon the reported imputed income. This imputed income is not an amount added to your total premium paid. It is additional taxable income based upon the fair market value of the non-federally qualified dependent's coverage. Check with your agency HBA for an approximation of the fair market value for State-administered health coverage.

- **For Retirees** covering a non-federally qualified dependent, the State will issue a 1099-MISC to you and the IRS at the end of the tax year. This form reports the fair market value of the non-federally qualified dependent's coverage as additional income which may increase your total tax liability for the year. Check with the Employee Benefits Division for an approximation of the fair market value for State-administered health coverage.

Please note, incorrectly reporting your Domestic Partner's status as a federally qualified dependent constitutes fraud and could have serious negative tax implications.

Pre-Tax Contribution Program (PTCP)

State employees who cover a federally qualified Domestic Partner may have their full premium contribution for the cost of Family health insurance coverage deducted from their wages before taxes are withheld.

If you are enrolled in the PTCP, but your Domestic Partner is not a federally qualified dependent, the cost of Individual coverage will be deducted from your paycheck before taxes have been withheld, while the cost of dependent coverage will be deducted on a post-tax basis.

Under the PTCP, once you elect to change your coverage to Family Coverage to add a federally qualified Domestic Partner, you may not change your election back to Individual coverage unless you experience a qualifying event (such as a terminated partnership), the consistency rule is satisfied, and the change is requested within 30 days of the qualifying event.

Other Pertinent Information

When Domestic Partner Coverage Begins

Your Domestic Partner is first eligible for coverage six months after your Partnership Establishment Date.

If you apply for Domestic Partner coverage within 30 days of the date of first eligibility (six months after your Partnership Establishment Date), your Domestic Partner may be enrolled in NYSHIP coverage on the date of first eligibility.

If you apply for Domestic Partner coverage more than 30 days after the date of first eligibility, your Domestic Partner will be subject to a late enrollment period. Refer to the appropriate group below for information on when Domestic Partner coverage begins after a late enrollment period.

- **For Active Employees,** Domestic Partner coverage begins on the first day of the fifth pay period following the pay period in which you apply.
- **For Retirees,** Domestic Partner coverage begins on the first day of the third month following the month in which you apply.

Domestic Partners and Medicare

Your Domestic Partner must enroll in Medicare Parts A and B when one of the following occurs:

- Your Domestic Partner turns 65 years old;
- Your Domestic Partner has completed the Medicare 30-month coordination period for end-stage renal disease; or
- You are enrolled in coverage as a retiree and your Domestic Partner qualifies for Medicare prior to age 65 due to a disability or amyotrophic lateral sclerosis (ALS).

If you are enrolled in NYSHIP coverage as an active employee, your Domestic Partner is not required to enroll in Medicare if he or she is eligible due to disability and under age 65.

If your Domestic Partner meets one of the criteria listed above and is required to enroll in Medicare, you must provide your Domestic Partner's Medicare Claim Number and dates of enrollment in Medicare Part A and Part B. If you are a Retiree, send this information to: New York State Department of Civil Service, Employee Benefits Division, Albany, NY 12239. For all other enrollees, you should submit this information to your agency HBA. Your Domestic Partner's benefits will be drastically reduced if you do not follow these requirements.

Domestic Partnership Terminations

NYSHIP dependent coverage for your Domestic Partner will end on the date your domestic partnership ends or when you are no longer able to provide proof of your Domestic Partner's continued eligibility as required by NYSHIP. In addition, when covering a child of a Domestic Partner, the child's coverage will end upon termination of your domestic partnership. You must complete and submit Form PS-425.4, Termination of Domestic Partnership, within **30 days** of the date the relationship ends or cannot be documented. This form can be obtained in your personnel office or can be found on the NYS Department of Civil Service website: https://www.cs.ny.gov/forms/ps425-4.pdf.

If you do not file Form PS-425.4 on a timely basis, you will be liable for claims paid for services rendered on and after the date the domestic partnership ended. Failure to remove an ineligible Domestic Partner may result in disciplinary action by your employer or prosecution for insurance fraud.

Note: You may not enroll another Domestic Partner or reenroll the same Domestic Partner until one year after the date the Termination of Domestic Partnership form is filed. Your former Domestic Partner's 60-day eligibility period for applying for COBRA continuation coverage starts on the date the relationship terminates, not the date you file Form PS-425.4.

Completed forms should be returned to University Administration Building (UAB), Room 300.

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

PS-404 (9/17)

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 *See bottom of page 2*

B. Select a NYSHIP Coverage Option (Choose option 1, 2, 3 or 4) CSEA and UUP represented employees enroll in dental and vision through their union

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 Pre-Tax Contribution Program, you may make changes during the Annual Option Transfer Period or when experiencing a 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: __________

* If enrolling a newborn or newly adopted child, please submit this form to UAB 300 within 30 days of birth/adoption even if Social Security numbers have not yet been obtained

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						

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 Selection Period (November 1-30)

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:**

*For new enrollments: Failure to elect a tax status will signify your election to have your contributions taken on a post-tax basis. Changes to your tax status can be made in accordance with the Pre-Tax Contribution program (PTCP) guidelines, typically during the month of November for the following plan year. Enrollments not made during a period of initial eligibility may be required to be processed on a post-tax basis.

EMPLOYEE BENEFITS DIVISION

Termination of Domestic Partnership

PS-425.4 (3/17)

I, ____ certify that:
Name of Enrollee (Please Print)

I, ______________________________ and ______________________________
Name of Enrollee (Please Print) *Name of Domestic Partner (Please Print)*

have terminated our domestic partnership.

I affirm that the effective date of termination of this domestic partnership is: ____________________
Date

I affirm that a copy of this termination statement has been or will be provided to my former Domestic Partner within 30 days of termination of this domestic partnership.

I understand that I may not enroll another Domestic Partner, or reenroll the same Domestic Partner, until **one year** after the date this form is filed.

I understand that my partner's children named below, if any, that are covered under my NYSHIP enrollment will end (unless otherwise eligible) on the termination date of this domestic partnership.

Domestic Partner's child's/children's name(s): ______________________________

I affirm that assertions in this notice are true to the best of my knowledge and understand that any false or misleading statements made subject me to financial responsibility for any benefits paid on behalf of my partner and/or my partner's children. I understand that false statements may result in disciplinary action by my employer and/or result in criminal and/or civil penalties and in other legal actions such as the prosecution of insurance fraud.

Signature of Enrollee ***(sign in the presence of a Notary)***:	Date:
Social Security Number:	

Subscribed and sworn to before me on this ______________ day of ____________, ________

____
NOTARY PUBLIC

Personal Privacy Protection Law Notification

The information you provide on this application is requested for the principal purpose of administering the New York State Health Insurance Program, Dental Program, Vision Program, and/or Employee Benefit Fund Program. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law. Failure to provide the information requested may prevent the Department from processing this application. This information will be maintained by the Employee Benefits Division, NYS Dept. of Civil Service, Albany, NY 12239. For information related to the Personal Privacy Protection Law, call (518) 457-9375. **For more information concerning the Domestic Partnership Program, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 4:00 p.m.**