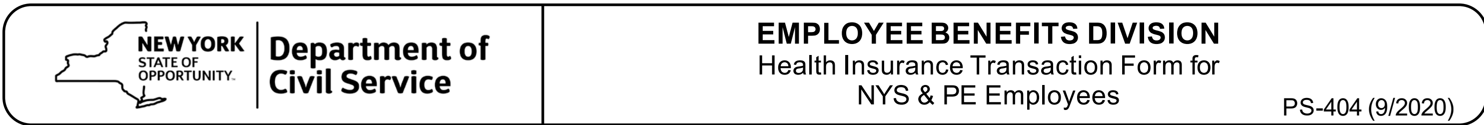
Completed forms should be returned to University Administration Building (UAB), Room 300. *To switch from a Health Plan to the Opt-Out 2 Forms: PS-404 & PS-409

1



EMPLOYEE BENEFITS DIVISION
Health Insurance Transaction Form for NYS & PE Employees

PS-404 (9/2020)

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. Personal Email Address

10. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated — Marital Status Date

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

12. 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 *See bottom of pg 2.

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) CSEA and UUP represented employees enroll in dental and vision through their union

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

13. CHANGE OR CANCEL EXISTING COVERAGE

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

☐ **Change to FAMILY** *(Complete box 14)*
- ☐ 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 14 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.

14. 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.

		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						

15. 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, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

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): Justin Case **Date:** 11/20/2020

AGENCY USE ONLY

Retirement Tier	Registration #	Sick Leave Information # Hours	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 Option transfer Period (OTP) 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.

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

You must provide either a copy of your health insurance card or a letter from your employer or other health insurance provider confirming current coverage *

Department of Civil Service

EMPLOYEE BENEFITS DIVISION

Opt-out Program Attestation Form

PS-409 (8/19)

EMPLOYEE INFORMATION

Last Name	First Name	M.I.
Date of Birth	NYS Employee ID (from payroll check) N __ __ __ __ __ __ __ __	Agency Name

Home Address	City	State	Zip
Work Address	City	State	Zip

Telephone Numbers Home ( ) Work ( )

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

NYSHIP HEALTH BENEFITS OPT-OUT ELECTION

If you are eligible to Opt-out, please **check one:**

☐ I am electing to **Opt-out of Individual coverage** in exchange for a $1,000 taxable payment ($38.47 over 26 biweekly paychecks).

☐ I am electing to **Opt-out of Family coverage** in exchange for a $3,000 taxable payment ($115.39 over 26 biweekly paychecks).

For questions regarding eligibility for the Opt-out Program, see your Health Benefits Administrator (HBA) or the publications *Planning for Option Transfer* and your *General Information Book* available at NYSHIP Online www.cs.ny.gov/employee-benefits.

OTHER EMPLOYER-SPONSORED GROUP HEALTH INSURANCE INFORMATION

You must have other employer-sponsored group health insurance to be eligible for the Opt-out Program.
Other employer-sponsored group health coverage **cannot be**:

- The result of your or your spouse's, domestic partner's or parent's employment relationship with NYS, or
- The result of your own employment with a NYSHIP Participating Agency (PA) or Participating Employer (PE).

I have other employer-sponsored group health insurance coverage… (please check one)

☐ as a dependent on another person's policy ☐ through my own employment.

My other employer-sponsored group health insurance coverage is… (please check one)

☐ NYSHIP coverage ☐ Not NYSHIP coverage

Other employer-sponsored group health insurance policy holder information:

Name of Policy Holder ______________________________

Policy Holder's Employer ______________________________

Employer's address ______________________________

Other employer-sponsored group health insurance plan information:

Plan Name ______________________________ Effective Date of Coverage ______________

Plan Address ______________________________

(You **must** provide either a copy of your health insurance card or a letter from your employer or other health insurance provider confirming current coverage.)

Department of Civil Service

EMPLOYEE BENEFITS DIVISION

Opt-out Program Attestation Form

PS-409 (8/19)

ATTESTATION

I have read the Opt-out Program materials and instructions and I attest to the following:

- I meet the qualifications to elect the Health Insurance Opt-out Program.
- I understand that I must promptly report changes that may impact my eligibility or payment amount (e.g., loss of other employer-sponsored coverage, divorce, death, last dependent loses eligibility for NYSHIP coverage) If I fail to do so, I am responsible for any Opt-out Program payments made to me in error. I understand that Opt-out Program payments made to me in error may be recovered as special deductions of up to $200 from my biweekly paycheck.
- I understand that I may choose to opt out of Family coverage only if I have NYSHIP eligible dependents and I am not enrolled in NYSHIP as a dependent or enrollee through NYS or another NYSHIP employer, and that I must provide proof of my dependent's eligibility when enrolling each year.

Employee's Signature (Required) Justin Case Date ____________________

The information you provide on this application is requested in accordance with Section 163 of 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 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.

This form is invalid if it is not signed and submitted along with a completed PS-404.

AGENCY USE ONLY

Date Received	Date Processed	HBA Initials

Please note: If both the PS-404 & PS-409 are not received and completed in their entirety, your paperwork will not be processed.