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

NEW YORK STATE OF OPPORTUNITY. 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.)

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE BENEFITS DIVISION

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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) _____ 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 <u>invalid</u> if it is not signed and submitted along with a completed PS-404.

AGENCY USE ONLY

Date Received	Date Processed	HBA Initials