



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
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
B. Select a NYSHIP Coverage Option (Choose option 1, 2, 3 or 4)
1. Individual Enrollment Medical (10) (Select Empire Plan or HMO) Dental (11) Vision (14)
2. Family Enrollment Medical (10) (Select Empire Plan or HMO) Dental (11) Vision (14)
3. Opt-out Program Individual Opt-out Family Opt-out 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) Change to INDIVIDUAL
B. Voluntarily Cancel Coverage: Medical (10) Dental (11) Vision (14) Qualifying Event:
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.

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)						Date of Event: _____			
Check all that apply: M (Medical), D (Dental), and V (Vision)									
		Last Name	First Name	MI	Relationship	Date of Birth	Sex	Address (if different)	Social Security Number
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								

15. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW		
Change NYSHIP Option	Change to: <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code <input style="width: 30px; border: 1px solid black;" type="text"/>	HMO Name: _____
Elect Opt-out <i>(NYS Medical only)</i>	<input type="checkbox"/> Individual Opt-out <input type="checkbox"/> Family Opt-out	If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.
Change Pre-Tax Status	Change to: <input type="checkbox"/> Pre-Tax <input type="checkbox"/> 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	
<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. 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.</p>	
Employee Signature (Required): _____	Date: _____

AGENCY USE ONLY					
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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