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

EMPLOYEE BENEFITS DIVISION
PA HEALTH INSURANCE TRANSACTION FORM
PS-503.1 (10/02) (w)

INSTRUCTIONS: READ AND COMPLETE BOTH SIDES. 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
   Home ( ) Work ( )
7 Work location and address
8 Marital Status
   □ Single □ Married □ Divorced □ Widowed □ Separated
   Marital Status Date
9 Covered under Medicare? Self □ Yes □ No Spouse/Domestic Partner □ Yes □ No Dependent □ Yes □ No

10 ENTER REQUEST(S) BELOW

A. □ Request Enrollment-Individually For Agency Use: (Select Empire Plan Option)
   7 (core plus med & psych) __________ 8 (core only) __________
B. □ Request Enrollment-Family (Complete G) For Agency Use: (Select Empire Plan Option)
   7 (core plus med & psych) __________ 8 (core only) __________
C. □ Decline Coverage For Agency Use only: Process waive benefits transaction
D. □ Voluntarily Cancel Coverage
E. □ Name Change Previous Name was:
F. □ Change Coverage Date of Event __________________________
   Change to FAMILY (Complete G)
   □ Marriage □ Domestic Partner □ First dependent child acquired
   □ Dependent returned to full-time student status
   □ Request coverage for dependents not previously covered
   □ Newborn □ Previous coverage terminated (Complete Section 11)
   □ Other __________________________
   Change to INDIVIDUAL
   □ I voluntarily cancel coverage for my dependents
   □ I voluntarily cancel coverage for my domestic partner
   □ Only dependent died
   □ Only dependent married
   □ Only dependent graduated
   □ Only dependent left school
   □ Divorce
   □ Only dependent disqualified by age
   □ Termination of domestic partnership (Attach Completed PS-427.4)
   □ Other __________________________
G. DEPENDENT INFORMATION (use additional sheets if necessary)
Check One: A (Add), D (Delete), C (Change), Medicare (M)
Date of Event __________________________ Is enrollee or spouse reimbursed by another agency? □ Yes □ No

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<thead>
<tr>
<th>A</th>
<th>D</th>
<th>C</th>
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<td>M</td>
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## Enter Request(s) Below

| H. | Change Retiree Payment status | Change to: | ☐ pension deduction (Rate ____/_____) | ☐ direct payment to agency (APAY) |
| I. | Correct Social Security Number | Incorrect SSN: |

### Previous Coverage Information

If you were previously covered under NYSHIP or another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.

| Previous ID Number | Date Coverage Terminated | Enrollee’s Name Under Which Previously Covered Last Initial Middle Initial |

### Leave Without Pay and Retirement Status

- ☐ I wish to continue coverage while I am on authorized leave. I understand that I will be billed for this coverage.
- ☐ I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll.
- ☐ 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 vestee and wish to continue my coverage.

### Request for Empire Plan Card

- ☐ DUPLICATE CARD (Previously issued card remains valid.)
- ☐ REPLACEMENT CARD (Previously issued card(s), lost or stolen, become invalid.)

### Personal Privacy Protection Law Notification

This information you provide on this application is being requested pursuant to Section 163 of the New York State Civil Service Law for the purpose of enabling the NYS 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 your Personnel Office and by the Employee Benefits Division, NYS Department of Civil Service, The State Campus, Albany, NY 12239. For further information relating only to 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 3:00 p.m.

### Authorization

I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving agency service (vest, retirement, etc.). I certify that the information I have supplied is true and correct. 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 misstatement of fact or conceals any pertinent information, commits a crime which is subject to a $5,000 penalty and the stated value of the claim for each violation. I hereby authorize deduction from my salary or retirement allowance of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

| Employee’s Signature (Required) | Signature Date (Required) |

### Agency/EBD Use Only

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<tr>
<th>Action/Reason</th>
<th>Date of Event</th>
<th>Hire Date</th>
<th>First Eligibility Date</th>
<th>Agency Code</th>
<th>Date Eligibility Lost</th>
<th>Retirement System</th>
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<thead>
<tr>
<th>Retirement Tier</th>
<th>Registration #</th>
<th>Pension Deductions</th>
<th>Date Entered on NYBEAS</th>
<th>Effective Date</th>
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| HBA Signature: | Date: |