Department of Civil Service
Employee Benefits Division

PS-503 (1/2025)
NYSHIP Health Insurance Transaction Form for Participating Agencies (PAs)
Department of Civil Service, Albany, NY 12239

INSTRUCTIONS: Please print, check the appropriate choices and sign/date the document.

EMPLOYEE INFORMATION

Last Name First Name MI

DEPENDENT INFORMATION

Must provide when enrolling or opting-out of NYSHIP family coverage
(You may attach additional sheets if necessary)
Date of event __ / __ / ____

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update
Last Name ____________ First Name ____________ MI ____ Relationship ____________
Date of Birth ____________ Gender ☐ F ☐ M ☐ X Social Security Number ____________

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update
Last Name ____________ First Name ____________ MI ____ Relationship ____________
Date of Birth ____________ Gender ☐ F ☐ M ☐ X Social Security Number ____________

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