REQUEST TO DECLINE AND WAIVE MEDICAL HEALTH INSURANCE COVERAGE

(Medical Buy-Out) - 2026 Enrollment Form

I,_____, as a benefits eligible employee, have been offered enrollment in **County of Orange** sponsored health benefits that meet the Affordable Care Act requirements of both affordability and minimum value standards. However, I hereby request to decline and waive my enrollment in **County of Orange** sponsored medical health insurance for the 2026 Plan Year (Jan. 1 – Dec. 31, 2026).

I understand that during the Plan Year 2026, I must be continuously covered by another **employer based** medical health insurance plan. I am requesting enrollment in the **2026 Orange County Medical Buyout**, subject to the rules and regulations of the plan.

Accordingly, I hereby certify that I will have coverage under the following medical health insurance plan for 2026:

Name of Health Insurance Plan for 2026: _____

This Coverage Belongs to: (Name of Plan Holder/Relationship) _____

Source of Coverage: (Employer Name) _____

Last 4 digits of your Social Security Number: xxx-xx_____

Last 4 digits of the Plan Holder's Social Security Number: xxx-xx_____

Is your spouse / parent employed by Orange County Government or O.C.C.C.: Yes____ No____

In making this request for 2026, I understand and agree that I and/or my dependents will not be eligible for **County of Orange** provided medical health insurance coverage for which I and/or my dependents would otherwise be eligible. Notwithstanding anything to the contrary in this form, I understand and agree that if I suffer an involuntary loss of this alternate coverage, I may apply to enroll in **County of Orange** medical health insurance coverage.

I understand and agree that my **Request to Decline and Waive Medical Health Insurance Coverage** shall remain in effect throughout the 2026 calendar year unless I suffer an involuntary loss of alternate coverage. In order to enroll in the medical health insurance coverage provided by the **County of Orange**, I understand that I must complete and submit to the Office of Risk Management a "Request to Resume Medical Health Insurance Coverage" and provide proof of the involuntary loss of coverage along with **a completed Change of Circumstance form**. The effective date of my medical health insurance coverage shall be subject to and conditioned on the requirements of the Employer's medical health insurance carrier(s) and the Office of Risk Management.

Employee Signature _____ **Date:** _____

Print Name_____

APPROVED BY Risk Management: Yes _____ No _____ Date_____

Risk Management 255-275 Main Street Goshen NY 10924 845/615-3600

Revised 7/28/23

OPEN ENROLLMENT 2026

NEW YORK STATE | **Department of Civil Service**
Employee Benefits Division

PS-503 (6/2025)
NYSHIP Health Insurance Transaction Form for Participating Agencies (PAs)
Department of Civil Service, Albany, NY 12239

INSTRUCTIONS: Read and complete both pages. Please print, check the appropriate choices and sign/date the document.

1–11 EMPLOYEE INFORMATION

1. Last Name First Name MI

2. Social Security Number **3.** Gender ☐ F ☐ M ☐ X

4. Permanent Address City State Zip

5. Mailing Address *(If different)* Street City State Zip

6. Date of Birth **7.** Telephone Primary ( ) Work ( )

8. Personal Email Address

9. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Marital Status Date _ _ / _ _ / _ _ _ _

10. Covered under Medicare?

☐ Self Medicare ID Number _____ Date _ _ / _ _ / _ _ _ _
Is the enrollee reimbursed for Medicare by another entity? ☐ No ☐ Yes

☐ Dependent Dependent Name _____
Medicare ID Number _____ Date _ _ / _ _ / _ _ _ _
Is the dependent reimbursed for Medicare by another entity? ☐ No ☐ Yes

11. Is any of this information new? ☐ No ☐ Yes Box Number(s) _____ Effective Date of Change _ _ / _ _ / _ _ _ _

12 ELECT COVERAGE

Enroll in New York State Health Insurance Program (NYSHIP)

Individual Enrollment ☐ Empire Plan
Family Enrollment *(Complete Box 13)* ☐ Empire Plan

☐ Empire Plan Decline

13 DEPENDENT INFORMATION

Must provide when enrolling or opting-out of NYSHIP family coverage
(You may attach the PS-404S Additional Dependent Information Supplement 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 _____
Address *(if different)* _____

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update

Last Name _____ First Name _____ MI ____ Relationship _____
Date of Birth _ _ / _ _ / _ _ _ _ Gender ☐ F ☐ M ☐ X Social Security Number _____
Address *(if different)* _____

☐ If you have additional dependents, please check this box and attach PS-404S with their information.

14 NOTIFICATION PREFERENCES

To change how you receive NYSHIP publications, select one option below. If no option is selected, you will continue to receive mail only. A valid personal email is required for email delivery. Some communications must be sent by mail.

☐ I would like to receive publications by email only. ☐ I would like to receive publications by email and mail.

15 CHANGE OR CANCEL EXISTING COVERAGE

15A. Change Coverage Qualifying Event:_____ Date of Event _ _ / _ _ / _ _ _ _

☐ **Change to FAMILY** *(Complete Box 13 on page 1)*	☐ **Change to INDIVIDUAL**
☐ Marriage	☐ Divorce
☐ Domestic Partner	☐ Termination of Domestic Partnership *(Attach completed PS-425.4)*
☐ Newborn	☐ Only dependent ineligible due to age
☐ Request coverage for dependents not previously covered	☐ I voluntarily cancel coverage for my dependents
☐ Previous coverage terminated *(proof required)*	☐ Only dependent died
☐ Other_____	☐ Other_____

15B. Voluntarily Cancel Coverage: Event/Reason_____ Date of Event _ _ / _ _ / _ _ _ _

16 RETIREMENT/VESTEE STATUS

I understand the requirements for continuing coverage as a retiree or vestee and wish to:

☐ **Continue** my coverage ☐ **Cancel** my coverage.

17 DONATE LIFE REGISTRY ELECTION

You must fill out the following section. This question must be answered each time the form is filled out.

Would you like to be added to the Donate Life Registry? ☐ Yes ☐ Skip this question

By indicating yes in response to the question asking if you would like to be added to the Donate Life Registry, you are certifying that you are 16 years of age or older, consenting to donate your organs and tissues for the purposes of transplantation and research in the event of your death and authorizing NYSHIP to share your name and identifying information with the Registry.

ID Number on New York State Driver License, Learner Permit, or Non-Driver ID Card _____

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. For information related to the Health Insurance Program, **contact your Health Benefits Administrator**. If, after calling your 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 4:00 p.m.

AUTHORIZATION

Pursuant to the following Sections of NYS Retirement and Social Security Law: 110-a; 110-b; 110-c; 110-d; 410-a; 410-b or 410-c, I hereby authorize the NYS Department of Civil Service (DCS) to deduct an amount from my monthly retirement allowance from the New York State and Local Retirement Systems (NYSLRS) to cover any deductions for insurance premiums payable on behalf of DCS. Authorization is given to make any future adjustment deductions and/or changes DCS certifies to NYSLRS as necessary in the amount of such insurance premiums. I understand that all requests to begin, modify, or revoke deductions must be submitted to my current/former agency and provided to DCS. This authorization shall remain in effect until revoked by me by written notice or until otherwise revoked pursuant to law.

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)*** _____ **Date** _ _ / _ _ / _ _ _ _

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	Date of 1st Eligibility	Percentage Working	Agency Code

Eligibility Lost Date	Retirement System	Retirement Tier	Registration #	Date Entered on NYBEAS	Effective Date

Change Retiree Payment Status to: ☐ Pension Deduction (Rate: _____ / _____) Direct Payment to Agency

▶ **HBA Signature** ***(Required)*** _____ **Date** _ _ / _ _ / _ _ _ _