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 ☐ Widowed ☐ Divorced ☐ 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- **Individual**	For Agency Use: *(Select Empire Plan Option)* 7 (core plus med & psych)_____ 8 (core only)____
B. ☐ Request Enrollment- **Family** (Complete G)	List dependents in section 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**

▼	Last Name First Name MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security #
☐ A ☐ D ☐ C ☐ M						
☐ A ☐ D ☐ C ☐ M						
☐ A ☐ D ☐ C ☐ M						
☐ A ☐ D ☐ C ☐ M						
☐ A ☐ D ☐ C ☐ M						

10 Cont'd **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:

11 **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 First Middle Initial

12 **LEAVE WITHOUT PAY AND RETIREMENT STATUS**

LEAVE WITHOUT PAY

☐ 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.

RETIREMENT/ VESTEE STATUS

☐ 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.

13 **REQUEST FOR EMPIRE PLAN CARD**

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

FOR

☐ ENROLLEE
☐ ENROLLEE AND ALL DEPENDENTS
☐ INDIVIDUAL DEPENDENT
Name _____

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

Action/Reason	Date of Event	Hire Date	First Eligibility Date	Agency Code	Date Eligibility Lost	Retirement System

Retirement Tier	Registration #	Pension Deductions		Date Entered on NYBEAS	Effective Date
		Yes_____	No_____		

HBA Signature: **Date:**