NEW YORK STATE OF OPPORTUNITY. **Department of Civil Service**

# EMPLOYEE BENEFITS DIVISION

## NYSHIP Health Insurance Transaction Form

for Participating Agencies (PAs)

PS-503 (6/2024)

***INSTRUCTIONS: READ AND COMPLETE BOTH PAGES. PLEASE PRINT, CHECK THE APPROPRIATE CHOICES AND SIGN/DATE THE DOCUMENT.***

## EMPLOYEE INFORMATION

| | | |
|---|---|---|
| **1.** Last Name First Name MI | **2.** Social Security Number | **3.** Gender ☐ F ☐ M ☐ X |
| **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 Medicare ID Number: _____ Date: _____ Is the enrollee reimbursed for Medicare by another entity? ☐ No ☐ Yes | | |
| ☐ Dependent Medicare ID Number: _____ Date: _____ Dependent Name: _____ Is the dependent reimbursed for Medicare by another entity? ☐ No ☐ Yes | | |
| **12.** Is any of this information new? ☐ No ☐ Yes Box Number(s): _____ Effective Date of Change: _____ | | |

## 13. ELECT OR DECLINE COVERAGE

**New or Newly Eligible Employees: Choose one of the following options (A or B)**

**A. Enroll in New York State Health Insurance Plan (NYSHIP) Coverage: Choose options 1 or 2**

| | | |
|---|---|---|
| 1. **Individual Enrollment** | ☐ Empire Plan | |
| 2. **Family Enrollment** *(Complete box 14)* | ☐ Empire Plan | |

**B. Decline New York State Health Insurance Plan (NYSHIP) Coverage** ☐

## 14. DEPENDENT INFORMATION

**Must be provided to enroll in family coverage** *(use additional sheets if necessary)*

**Check One: A (Add), D (Delete) or C (Change)** **Date of Event:** _____

| ↓ | Last Name First Name MI | Relationship | Date of Birth | Gender | Address *(if different)* | Social Security Number |
|---|---|---|---|---|---|---|
| ☐ A ☐ D ☐ C | | | | ☐ F ☐ M ☐ X | | |
| ☐ A ☐ D ☐ C | | | | ☐ F ☐ M ☐ X | | |
| ☐ A ☐ D ☐ C | | | | ☐ F ☐ M ☐ X | | |
| ☐ A ☐ D ☐ C | | | | ☐ F ☐ M ☐ X | | |

## 15. CHANGE OR CANCEL EXISTING COVERAGE

**A. Change Coverage:** Qualifying Event: _____ Date of Event: _____

☐ **Change to FAMILY** *(Complete box 14 on page 1)*

- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Other: _____

☐ **Change to INDIVIDUAL**

- ☐ Divorce
- ☐ Termination of Domestic Partnership *(Attach completed PS-425.4)*
- ☐ I voluntarily cancel coverage for my dependents
- ☐ Only dependent died
- ☐ Other: _____

**B. Voluntarily Cancel Coverage:** ☐ Event/Reason: _____ Date of Event: _____

## 16. RETIREMENT STATUS

| | | |
|---|---|---|
| **Retirement/ Vestee Status** | ☐ | I understand the requirements for continuing coverage as a retiree or vestee and wish to **continue my coverage**. |
| | ☐ | I understand the requirements for continuing coverage as a retiree or vestee and wish to **defer my coverage**. |

## 17. DONATE LIFE REGISTRY ELECTION

**You must fill out the following section:**

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

Check box for 'yes' or 'skip this question.'

**This question must be answered each time the form is filled out.**

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:** _____