Department of Civil Service
Employee Benefits Division

PS-404S (6/2025)
NYSHIP Health Insurance Transaction Form
Additional Dependent Information Supplement
Department of Civil Service, Albany, NY 12239

INSTRUCTIONS: Complete this form along with PS-404, PS-404R, PS-404G or PS-503 to include information for additional dependents.

ENROLLEE INFORMATION

Last Name First Name MI

DEPENDENT INFORMATION

NOTE: Dental and Vision coverage are only available to NYS and PE Employees.
Refer to PS-404 Instructions for more information.

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)* ________________________________

CHECK ALL THAT APPLY: ☐ Add ☐ Remove ☐ Update

Last Name ____________ First Name ____________ MI ____ Relationship ____________

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Address *(if different)* ________________________________