# NYS Health Insurance Transaction Form

**State of New York**  
**Department of Civil Service**  
Albany, NY 12239

**NYS Health Insurance Transaction Form**  
PS-404 (10/06)

**EMPLOYEE INFORMATION**  
*(All employees must complete)*

1. **Last Name**
2. **First Name**  
3. **MI**
4. **Social Security Number**
5. **Sex**
   - [ ] Male
   - [ ] Female

6. **Street Address**
7. **City**
8. **State**
9. **Zip**
10. **Date of Birth**

**EMPLOYEE BENEFITS DIVISION**

**INSTRUCTIONS:** READ AND COMPLETE BOTH SIDES/PAGES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.

**ENTER REQUEST(S) BELOW**

<table>
<thead>
<tr>
<th>A.</th>
<th>Request Enrollment-Individual</th>
<th>B.</th>
<th>Request Enrollment-Family (Complete G)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical (10) (Select Empire Plan or HMO)</td>
<td></td>
<td>Medical (10) (Select Empire Plan or HMO)</td>
</tr>
<tr>
<td></td>
<td>[ ] Empire Plan</td>
<td>[ ] HMO* Code</td>
<td>[ ] Name</td>
</tr>
<tr>
<td></td>
<td>[ ] Dental (11)</td>
<td>[ ] Vision (14)</td>
<td>[ ] Dental (11)</td>
</tr>
</tbody>
</table>

**C.** Elect Pre-Tax Status for Premium deduction?  
[ ] Yes  
[ ] No  
If yes, initial here to indicate that you have read the Pre-Tax Contribution memorandum.  

**D.** Decline Coverage  
[ ] Medical (10)  
[ ] Dental (11)  
[ ] Vision (14)  
*(Process WAV/BEN transaction)*

**E.** Voluntarily Cancel Coverage  
[ ] Medical (10)  
[ ] Dental (11)  
[ ] Vision (14)  
*(Process WAV/BEN transaction)*

**F.** Change Coverage  
[ ] Medical (10)  
[ ] Dental (11)  
[ ] Vision (14)  
*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
- [ ] Divorce
- [ ] Only dependent disqualified by age
- [ ] Termination of domestic partnership (Attach Completed PS-425.4)
- [ ] Other _____

**G.** DEPENDENT INFORMATION  
*(use additional sheets if necessary)*

**Check One: A (Add), D (Delete) or C (Change)**

**Check all that apply: M (Medical), D (Dental), and V (Vision)**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Address (if different)</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

* A completed HMO form must be attached.
10. **Continued.**

**ENTER REQUEST(S) BELOW**

H. □ Change Medical Benefit Plan

Change to: □ Empire Plan □ HMO *  
Code   HMO Name  

* A completed HMO form must be attached.

I. Change Pre-Tax Status

Change to: □ Pre-Tax □ Post-Tax

Processed only by the Employee Benefits Division during the Pre-Tax Contribution Selection Period (November)

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.

<table>
<thead>
<tr>
<th>Previous ID Number</th>
<th>Date Coverage Terminated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee’s Name Under</td>
<td>Last First Middle Initial</td>
</tr>
<tr>
<td>Which Previously Covered</td>
<td></td>
</tr>
</tbody>
</table>

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.  
□ Medical  □ Dental  □ Vision

□ I wish to resume my coverage upon return to the payroll.

RETIREMENT

□ 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 retiree and wish to defer my coverage.  
(A completed PS-406.2 must be attached.)

13. **REQUEST FOR EMPIRE PLAN CARD ONLY**

For Health Maintenance Organization (HMO) cards, contact your HMO.

□ 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 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 of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning 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 have read the Pre-Tax Contribution Program memorandum and have made my selection on Page 1 of this document, if applicable. 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 State 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 28 days (30 days for newborns) 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 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**

<table>
<thead>
<tr>
<th>Action/Reason</th>
<th>Date of Event</th>
<th>Hire Date</th>
<th>Date of 1st Eligibility (PE only)</th>
<th>Percentage Working</th>
<th>Agency Code</th>
<th>Neg. Unit</th>
<th>Ret. System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement Tier</td>
<td>Registration #</td>
<td>Sick Leave Information # Hours Hourly Rate of Pay</td>
<td>Date Entered on NYBEAS</td>
<td>Effective Date</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HBA Signature:  
Date: