



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

**EMPLOYEE BENEFITS DIVISION  
NYS HEALTH INSURANCE TRANSACTION FORM**

PS-404 (10/06)

**INSTRUCTIONS: READ AND COMPLETE BOTH SIDES/PAGES. 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	
4. Street Address				City	State	Zip	
5. Date of Birth		6. Telephone Numbers Home ( ) Work ( )		7. Work location and address			
8. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		Marital Status Date					
9. Covered under Medicare? Self <input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse/Domestic Partner <input type="checkbox"/> Yes <input type="checkbox"/> No					

**10. ENTER REQUEST(S) BELOW**

A. <input type="checkbox"/> Request Enrollment- <b>Individual</b>	Medical (10) <i>(Select Empire Plan or HMO)</i> <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO* Code <input type="text"/> Name <input type="text"/>		<input type="checkbox"/> Dental (11)	<input type="checkbox"/> Vision (14)
B. <input type="checkbox"/> Request Enrollment- <b>Family</b> (Complete G)	Medical (10) <i>(Select Empire Plan or HMO)</i> <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO* Code <input type="text"/> Name <input type="text"/>		<input type="checkbox"/> Dental (11)	<input type="checkbox"/> Vision (14)
C. <input type="checkbox"/> Elect Pre-Tax Status for Premium deduction?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, initial here to indicate that you have read the Pre-Tax Contribution memorandum. _____		
D. <input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Medical (10) <input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14)	<i>(Process WAV/BEN transaction)</i>		
E. <input type="checkbox"/> Voluntarily Cancel Coverage	<input type="checkbox"/> Medical (10)	Qualifying Event:	<input type="checkbox"/> Dental (11)	<input type="checkbox"/> Vision (14)
F. <input type="checkbox"/> Change Coverage <input type="checkbox"/> Medical (10) <input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14) <b>Date of Event:</b> _____				
<input type="checkbox"/> <b>Change to FAMILY</b> (Complete G)		<input type="checkbox"/> <b>Change to INDIVIDUAL</b>		
<input type="checkbox"/> Marriage		<input type="checkbox"/> I voluntarily cancel coverage for my dependents		
<input type="checkbox"/> Domestic Partner		<input type="checkbox"/> I voluntarily cancel coverage for my domestic partner		
<input type="checkbox"/> First dependent child acquired		<input type="checkbox"/> Only dependent died		
<input type="checkbox"/> Dependent returned to full-time student status		<input type="checkbox"/> Only dependent married		
<input type="checkbox"/> Request coverage for dependents not previously covered		<input type="checkbox"/> Only dependent graduated		
<input type="checkbox"/> Newborn		<input type="checkbox"/> Divorce		
<input type="checkbox"/> Previous coverage terminated (Complete Section 11)		<input type="checkbox"/> Only dependent disqualified by age		
<input type="checkbox"/> Other _____		<input type="checkbox"/> Termination of domestic partnership (Attach Completed PS-425.4)		
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____		

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

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

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

↓	↓	Last Name	First Name	MI	Relationship	Date of Birth	Sex	Address (if different)	Social Security Number
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								
<input type="checkbox"/> A	<input type="checkbox"/> M								
<input type="checkbox"/> D	<input type="checkbox"/> D								
<input type="checkbox"/> C	<input type="checkbox"/> V								

\* 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.	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.  Medical  Dental  Vision  
 I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll.  Medical  Dental  Vision

**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.

<input type="checkbox"/> DUPLICATE CARD (Previously issued card remains valid.)	<b>FOR</b>	<input type="checkbox"/> ENROLLEE
<input type="checkbox"/> REPLACEMENT CARD (Previously issued card(s), lost or stolen, become invalid.)		<input type="checkbox"/> ENROLLEE AND ALL DEPENDENTS
		<input type="checkbox"/> 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**

Action/Reason	Date of Event	Hire Date	Date of 1 <sup>st</sup> Eligibility (PE only)	Percentage Working	Agency Code	Neg. Unit	Ret. System

Retirement Tier	Registration #	Sick Leave Information		Date Entered on NYBEAS	Effective Date
		# Hours	Hourly Rate of Pay		
	<input type="text"/>				

<b>HBA Signature:</b> _____	<b>Date:</b> _____
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