



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

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

PS-404 (1/01L)

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

EMPLOYEE INFORMATION <span style="float: right;">(All employees must complete)</span>									
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"/> Single		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	Marital Status Date					
		<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated						
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-Individual		Medical (10) (Select Empire Plan or HMO) <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO* Code _____ Name _____			<input type="checkbox"/> Dental (11)		<input type="checkbox"/> Vision (14)		
B. <input type="checkbox"/> Request Enrollment-Family (Complete G)		Medical (10) (Select Empire Plan or HMO) <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO* Code _____ Name _____			<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)	(Process WAY/BEN transaction)				
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)	Date of Event _____				
Change to FAMILY (Complete G)				Change to INDIVIDUAL					
<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 _____					
G. DEPENDENT INFORMATION <span style="float: right;">(use additional sheets if necessary)</span>									
Check One: A (Add), D (Delete) or C (Change)									
Check all that apply: M (Medical), D (Dental), and V (Vision)									
Date of Event _____									
↓	↓	Last Name	First Name	MI	Relationship	Date of Birth	Sex	Address (if different)	Social Security #
<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.

