

10. Continued. ENTER REQUEST(S) BELOW

H. Change NYSHIP Option Change to: Empire Plan HMO Code HMO Name _____ Opt-Out

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 enrolled in a NYSHIP plan, or were covered another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section. | Previous ID Number | Date the other 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.

DUPLICATE CARD (Previously issued card remains valid.) **FOR** ENROLLEE
 ENROLLEE AND ALL DEPENDENTS
 INDIVIDUAL DEPENDENT
Name _____

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 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 st 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"/> | | | | |

HBA Signature: _____ **Date:** _____