



STATE OF NEW YORK
DEPARTMENT OF CIVIL SERVICE
THE STATE CAMPUS
ALBANY, NEW YORK 12239

EMPLOYEE BENEFITS DIVISION

**NYS GOVERNMENT EMPLOYEES'
HEALTH INSURANCE
COORDINATION OF BENEFITS FORM**

PS-600 (4/99) (w)

The State Health Insurance Program has a Coordination of Benefits Provision that applies when you or any dependent receive benefits under more than one health insurance program. Coordinating benefits helps to contain the cost of health care and can save you some out-of-pocket expenses when balances remain after one carrier has made its claim payment.

Please return the completed form to your agency Health Benefits Administrator.

ALWAYS COMPLETE SECTION I.- EMPLOYEE INFORMATION

SECTION I. EMPLOYEE INFORMATION	NAME: LAST	FIRST	M.I.	CIRCLE ONE PREFIX NY or PA	SOCIAL SECURITY NUMBER	DATE OF BIRTH
	STREET ADDRESS				MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	CITY	STATE	ZIP CODE	EMPLOYING AGENCY	AGENCY CODE	

SECTION II. OTHER COVERAGE A:	NAME OF DEPENDENT WITH OTHER COVERAGE	POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH	SEX
	NAME OF OTHER EMPLOYER	ADDRESS OF OTHER EMPLOYER		
	NAME OF OTHER INSURANCE CARRIER	ADDRESS OF OTHER INSURANCE CARRIER		
	TYPE OF COVERAGE <input type="checkbox"/> Individual <input type="checkbox"/> Family	COMMENTS		

SECTION II. OTHER COVERAGE B:	DO NOT WRITE IN THIS SPACE						
	Status	T. Carrier	Emp. Code	Carrier Code	Cov.	Sec.	Ins. Sex
	NAME OF DEPENDENT WITH OTHER COVERAGE	POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH	SEX			
	NAME OF OTHER EMPLOYER	ADDRESS OF OTHER EMPLOYER					
	NAME OF OTHER INSURANCE CARRIER	ADDRESS OF OTHER INSURANCE CARRIER					
TYPE OF COVERAGE <input type="checkbox"/> Individual <input type="checkbox"/> Family	COMMENTS						

DO NOT WRITE IN THIS SPACE						
Status	T. Carrier	Emp. Code	Carrier Code	Cov.	Sec.	Ins. Sex

IF ADDITIONAL DEPENDENTS HAVE OTHER COVERAGE, CHECK HERE

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION: This information is being requested pursuant to §163 of the New York State Civil Service Law for the purpose of determining the availability of benefit coordination and to maintain up-to-date records for covered employees and their dependents. This information will be used in accordance with §96(1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide this information may result in a delay in the payment of benefits. While this information will be maintained by the Insurance Carrier, the Director of the Employee Benefits Division, Department of Civil Service, The State Campus, Albany, NY 12239, is responsible for these records and information contained therein may not be released without the Director's authorization.

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT

SIGNATURE: _____ DATE: _____

FOR FURTHER INFORMATION ON THE COORDINATION OF BENEFITS FORM, CONTACT YOUR PERSONNEL OFFICE.

Agency Information:

Attach this form to a COB Transmittal Notice (PS-601) and **mail directly to Central Enrollment File at Empire Blue Cross/Blue Shield.**