



**Office of
General Services**

**Business
Services Center**



New/Transfer Employee Guide

Filling out Forms & Understanding Benefits

Welcome

Welcome to your career with New York State government. The New/Transfer Employee Guide is an overview of everything you need to know to successfully integrate into your new job, including which forms you must fill out and what benefits are available to you. With the assistance of your agency's human resource professionals, and the Business Services Center, you'll be off to the right start with all the proper paperwork in place.



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New Employee Guide

Forms How-To for All New Employees/Transfers



New/ Employee Checklist

The BSC will provide you with a copy of this checklist and the Employee Enrollment Deadlines & Insurance Effective Date form, which are customized with your information based on your start date.

The checked items on the checklist are links to required and optional forms as well as information on all the benefits and services available to you as a New York State employee.

Please complete all checked forms in sections 1 through 4.

You may want to keep a copy of the checklist for your reference.

Sample View: New Employee Checklist.

**Office of General Services**
Business Services Center

New Employee Checklist

Employee Name	Start Date	Agency	Agency Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Title	Employee ID #	Bargaining Unit	
<input type="text"/>	<input type="text"/>	Select Bargaining Unit	

The following items have been given to the employee for completion or informational purposes. In addition, the new employee is provided with an Employee Enrollment Deadlines & Insurance Effective Date Form. This form is customized by the employee's start date to outline all deadlines for submitting Section 1 forms below.

For more information & guidance on the completion of these forms, see the BSC Information Series publication: [New Employee Guide to Filling Out Forms & Understanding Benefits.](#)

Section 1: FORMS FOR ALL EMPLOYEES to be completed by all new employees & returned to the BSC unless otherwise noted.

- Employee Enrollment Deadlines & Insurance Effective Date Form - This form is employee-specific and will be provided by your agency's HR office
- [Employment Eligibility Verification Form \(I-9\)](#) - Must be presented to your authorized agency representative with original documentation and submitted to the BSC within 3 days of appointment - only original form is accepted.
- [Oath of Office Statement](#) Only original form is accepted - For more information, see [Public Officer's Law booklet](#)
- [Oath of Office Statement for Appointed Officials](#) Only original form is accepted - For more information, see [Public Officer's Law booklet](#)
- [NYS Retirement Article 15 Membership Registration Application RS 5420 \(Includes RS 5127 Designation of Beneficiary\)](#) This form needs to be notarized
- [Retirement System Declination Form for Optional Employees](#) To be completed only if employee declines enrollment in the NYS Retirement System.
- [PS-404: Health Insurance Transaction Form](#) For health insurance enrollment; return with required documentation within the first 42 or 56 days of employment (see Employee Enrollment Deadlines & Insurance Effective Date Form for specific deadline), whether enrolling or declining. Failure to return on a timely basis will delay coverage. An Empire Plan or HMO packet with benefit information will be ordered upon receipt of the PS-404.
- [PS-409: Employee Benefits Division Opt-Out Form](#) To be completed only if employee has another employer-sponsored health insurance coverage and enrolls in the Opt-out program.
- [Veteran's Identification Form](#) To be completed only if employee claims Veteran status.
- [IT-2104: New York State Withholding Certificate](#)
- [W-4: Federal Withholding Certificate](#)
- [Direct Deposit Form \(AC-2772\)](#) Optional - may be returned at anytime.
- Civil Service NYS Self-Identification of Employee Disability Status This form is distributed to employees from their agency onboarding liaison.

Section 2: PEF MEMBERS ONLY Forms & information for PEF members only. Learn more about PEF online: <http://www.pef.org/>

- [PEF Membership Application](#)
- [PEF Vision Plan Information](#) Information only - no form to be returned.
- [PEF Dental Information \(GHI Dental\)](#) Information only - no form to be returned.

Section 3: CSEA MEMBERS ONLY Forms & information for CSEA members only. Learn more about CSEA online: <https://cseany.org/>

- [CSEA Membership Application](#)
- [CSEA Employee Benefits Fund Forms](#) Multiple forms for CSEA-member benefits only.

Section 4: M/C ONLY Forms & information for M/C employees only. Learn more about M/C benefits online: <http://nysomce.org/>

<input type="checkbox"/> M/C Vision Plan Information	<input type="checkbox"/> M/C Life Insurance Information
<input type="checkbox"/> M/C Dental Insurance Information (GHI Dental)	<input type="checkbox"/> M/C Life Beneficiary Designation Form
<input type="checkbox"/> M/C Dental Care Claim Form	<input type="checkbox"/> M/C Life Insurance Cost Calculator
<input type="checkbox"/> GOER M/C Employee Information	<input type="checkbox"/> M/C Life Insurance Bi-Weekly Rates
<input type="checkbox"/> M/C Income Protection Plan Benefit Information	<input type="checkbox"/> M/C Life Insurance Transaction Form (PS-934)
<input type="checkbox"/> M/C Income Protection Plan Enrollment Form	<input type="checkbox"/> M/C Voluntary Defined Contribution Information & Enrollment
<input type="checkbox"/> M/C Income Protection Plan Enrollment Addendum	

Continued 

New Employee Guide

Forms How-To for All New Employees/Transfers



Employment Eligibility Verification Form (I-9)

Download: [Employment Eligibility Verification form \(I-9\)](#)

What is this form for? To document verification of the identity and employment authorization of each new employee (both citizen and non-citizen) hired after November 5, 1986, to work in the United States. [Learn more about the I-9 Employment Eligibility Verification form.](#)

Is this form mandatory? Yes. For any new State employee or current employee transferring between agencies, the Employment Eligibility Verification form (I-9) must be fully completed by the employee & employer within 3 business days of the employees first days of employment.

How do I fill it out? Employees must:

- Download the form.
- Complete Section 1 located on page 1. This form is fillable - you may type your information in each of the fields.
- This form requires your signature. After completing Section 1, print out the form and sign it.
- On page 4, see the list of acceptable documents. You must present one valid selection from List A or a combination of one valid selection from List B and one valid selection from List C.
- Your agency representative is responsible for completing Section 2 and 3 of the I-9 form, located on page 4, on behalf of your agency employer.

How to submit this form:

- ⚠ Only the original, signed hard copy of this form is accepted
- ✍ Signature Required
- 📎 Attach copies of all documents listed on Section 2 of the form
- 🕒 Within 3 business days of start date
- ✉ By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Sample View: Employment Eligibility Verification (I-9), page 1

Employee
Completes
Section 1

Instructions Start Over Print

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 5415-0047
Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identify. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)

Last Name (Family Name) First Name (Given Name) Middle Initial Other Last Names Used (if any)

Address (Street Number and Name) Apt. Number City or Town State ZIP Code

Date of Birth (mm/dd/yyyy) U.S. Social Security Number Employee's Email Address Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

1. A citizen of the United States

2. A noncitizen national of the United States (See instructions)

3. A lawful permanent resident (Alien Registration Number/USCIS Number)

4. An alien authorized to work (expiration date, if applicable, mm/dd/yyyy).
Some aliens may write "N/A" in the expiration date field. (See instructions)

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number
OR
2. Form I-94 Admission Number
OR
3. Foreign Passport Number
Country of Issuance

Signature of Employee Today's Date (mm/dd/yyyy)

Preparer and/or Translator Certification (check one):

I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator Today's Date (mm/dd/yyyy)

Last Name (Family Name) First Name (Given Name)

Address (Street Number and Name) City or Town State ZIP Code

Click to Finish

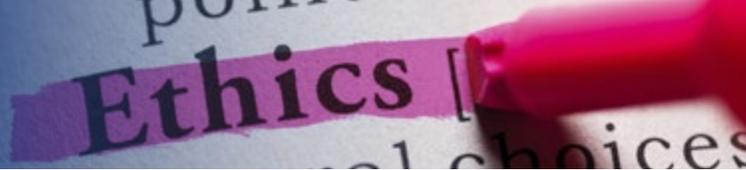
Employer Completes Next Page

Form I-9 11/14/2016 N Page 1 of 4

Employee
Signature

New Employee Guide

Forms How-To for All New Employees/Transfers



Oath of Office Statement

Download: [Oath of Office Statement](#)

What is this form for? The Public Officers Law and Civil Service Law each require public officers to file an oath of office certification or an alternative statement. This form is used for State employees and public officers to satisfy this requirement.

Is this form mandatory? Yes. Any new State employee or current employee transferring between agencies must complete this form. In addition, State employees are mandated to receive and review a copy of the Public Officers Law Sections 73, 73-a, 74, 75, 76, 77, 78. You may also [download a copy of the Public Officers Law](#) on the NYS Joint Commission on Public Ethics (JCOPE) website.

How do I fill it out?

- Download the form.
- This form is fillable. Complete the form by typing in your information in each of the fields.
- Refer to your New Employee Checklist for the agency code.
- This form requires your signature — print out the form and sign it in two locations.

How to submit this form:

 Only the original, signed hard copy of this form is accepted

 Signature required in both locations

 Within 3 days start date

 By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Sample View: State Employee Statement in Lieu of Oath

NEW YORK
STATE OF OPPORTUNITY

**Division of Corporations,
State Records and
Uniform Commercial Code**

**Department of State
DIVISION OF CORPORATIONS
STATE RECORDS AND
UNIFORM COMMERCIAL CODE**

State Employee Statement in Lieu of Oath Pursuant to Civil Service Law § 62

(TYPE ALL INFORMATION -- SIGN IN BLACK INK)

Name of Appointee: _____
(Last Name) (First Name) (Middle Initial)

I do hereby pledge and declare that I will support the constitution of the United States, and the constitution of the State of New York, and that I will faithfully discharge the duties of the position of

Title of Position: _____

Agency Name: _____

Agency Code: _____

_____ according to the best of my ability.

Employee Signature Required  X _____
(Signature of Appointee) (Date)

PUBLIC OFFICERS LAW §78 CERTIFICATE

I, the Appointee named above, hereby acknowledge receipt of a copy of sections 73, 73-a, 74, 75, 76, 77 and 78 of the Public Officers Law, together with such other material related thereto as may have been prepared by the Secretary of State, and I acknowledge that I have read the same and that I undertake to conform to the provisions, purposes and intent thereof and to the norms of conduct for members, officers and employees of the legislature and state agencies.

Employee Signature Required  X _____
(Signature of Appointee) (Date)

(Appointee must sign both the State Employee Statement in Lieu of Oath and the Public Officer's Law §78 Certificate)

Go to www.dos.ny.gov for filing instructions.

DOS-1690-f (Rev. 03/16) Page 1 of 1

New Employee Guide

Forms How-To for All New Employees/Transfers



Oath of Office Statement for Appointed Officials

Download: [Oath of Office Statement for Appointed Officials](#)

What is this form for? The Public Officers Law and Civil Service Law require elected officials to take and file an oath of office certification or an alternative statement. This form is used for elected officers to satisfy this requirement.

Is this form mandatory? This form is mandatory for **appointed officials only**. If you are not an appointed official, you must complete the Oath of Office Statement, see previous page. In addition, new state employees are mandated to receive and review a copy of the Public Officers Law Sections 73, 73-a, 74, 75, 76, 77, 78. You may also [download a copy of the Public Officers Law](#) on the NYS Joint Commission on Public Ethics (JCOPE) website.

How do I fill it out?

- Download the form.
- This form is fillable. Complete the form by typing in your information in each of the fields.
- Refer to your New Employee Checklist for the agency code.
- Notarize the form.
- This form requires your signature — print out the form and sign it in two locations.

How to submit this form:

⚠ Only the original, signed hard copy of this form is accepted

✍ Signature required in both locations

🕒 Within 3 days start date

✉ By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Sample View: Public Officer Oath of Office Statement

The form is titled "State Employee Oath/Affirmation" and includes the New York State logo and the Department of State, Division of Corporations, State Records and Uniform Commercial Code. It contains fields for Name of Appointee (Last Name, First Name, Middle Initial), STATE OF NEW YORK, and COUNTY OF. Below these are sections for Title of Position, Agency Name, and Agency Code. A signature line is marked with an 'X' and labeled "Employee Signature Required". A notarization section is marked with an arrow and labeled "Notarization". Another signature line is marked with an 'X' and labeled "Employee Signature Required". The form concludes with the "PUBLIC OFFICERS LAW §78 CERTIFICATE" and a date line. At the bottom, it states "(Appointee must sign both the State Employee Oath/Affirmation and the Public Officer's Law §78 Certificate)", provides the form number DOS-1691-f (Rev. 02/16), a link to www.dos.ny.gov for filing instructions, and the page number Page 1 of 1.

Agency Code

Employee Signature Required

Notarization

Employee Signature Required

New Employee Guide

Forms How-To for All New Employees/Transfers

Retirement Plan



New York State Employee's Retirement Membership Registration Application (RS-5420)

Download: [Employees' Retirement System \(ERS\) Membership Registration RS-5420 \(Includes RS-5127 Designation of Beneficiary\)](#)

What is this form for? To enroll in the NYS Employees' Retirement System.

Is enrollment in the ERS mandatory? All permanent, full-time, 12-month, NYS employees are required to join the New York State and Local Retirement System (ERS). **If you are already a member of the Employee's Retirement System you must still complete this form to update your information with the Retirement System and payroll.** If you are not already a member of the Employee's Retirement System and your employment is on a part-time, temporary, less than 12 months per year or you are eligible for and elect to join the Voluntary Defined Contribution Plan, membership is optional. (For information on the Voluntary Defined Contribution Plan see page 22 of this guide.)

- Employees hired on or after 4/1/2012 are Tier 6 members of ERS.
- Tier 6 ERS members contribute a specific percentage of gross earnings to ERS and become vested and earn the right to retirement benefits in the form of a pension after 10 full years of service.
- Employees who separate from State service before vesting are eligible to withdraw their contributions.
- Tier 6 ERS members' contribution rate varies depending on gross earnings. See the table below for contribution rates.

Annual Salary	Contribution Rate
Less than or equal to \$45,000	3%
\$45,000.01 - \$55,000	3.5%
\$55,000.01 - \$75,000	4.5%
\$75,000 - \$100,000	5.75%
\$100,000 and over	6.0%

How do I fill it out?

- [Download the form.](#)
- This form is fillable. Complete the form by typing in your information in each of the fields.
- Page 1: Fill out items 1-3. The BSC completes items 4-9a.

Sample View: Employees' Retirement System Membership Registration, page 1

Office of the New York State Comptroller

 New York State and Local Retirement System
 110 State Street, Albany, New York 12244-0001

Employees' Retirement System Membership Registration

RS 5420

(Rev. 8/16)

If your employment is on a part-time, temporary or provisional basis, or less than 12 months per year, membership is optional.
IF YOUR MEMBERSHIP IS OPTIONAL, DO NOT COMPLETE OR SUBMIT THIS FORM UNLESS YOU DESIRE TO BECOME A MEMBER.

Instructions: Please print clearly in ink or type. Application must be signed on last page. Notarization is no longer required.
Employee: Complete items 1-3, 10-13 on page 2 and other applicable sections. **Employer:** Complete items 4-9a.
FOR A REGISTRATION NUMBER: Call 1-866-805-0990 or (518) 474-3081. Or fax the application to (518) 486-4382.
This completed membership application must be mailed to the Retirement System for the membership to be effective.

Receipt Stamp
For OSC use only

IMPORTANT INFORMATION: Has this person been registered to membership by means of the telephone or fax registration system? Yes No (If yes, enter the information given to you in the boxes below.)

In order to complete the registration process this membership registration form must be received by the Retirement System.

Location Code	Report Code	Plan Code	Group Code	Date of Membership	Tier	Registration Number	Rate
				Mo. Day Year			

Employee's Name Last: First: Middle Initial:

Employee's Address Street and/or PO Box #: City: State: Zip Code + 4:

3 Date of Birth Month: Day: Year: **Sex** M F

***Social Security Number**

Maiden or Other Name Used

*NOTE: In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Sections 11, and 34 of the Retirement and Social Security Law. Your number will be used in identifying your retirement records and in the administration of the Retirement System.

Employer Name (Indicate State, or, if not, name of public entity by which employed and Department, Division, or Institution)

4

Employer's Address Street: City: County: State: Zip Code + 4: **Employer Telephone Number**

5

Payroll Title:

6 10 Months 12 Months Seasonal **Employer Fax Number**

Check if Either Applies Appointed Official Elected Official *If accountant, auditor, physician, attorney, engineer or architect please submit documentation as indicated at www.osc.state.ny.us/retire/employers/classify_an_employee.php

Enter the Date or Dates Relating to Employee's Present Position:

Part-Time Employment						Full-Time Employment					
Date of First Appointment			Date of Permanent Appointment			Date of Temporary or Provisional Appointment			Date of Permanent or Probationary Appointment		
Month	Day	Year	Month	Day	Year	Month	Day	Year	Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Frequency of Payment:

8 Annually Semi-Annually Quarterly Monthly
 Semi-Monthly Bi-weekly Weekly Other - Please Specify

Basis of Compensation and Rate (Tier 1, 2, 3, 4 and 5 ONLY):

9 Annual \$ Daily \$ Hourly \$
 Units of Work Performed \$ per (Example: \$50 per meeting or \$10 per examination, etc.)

Basis of Compensation and Rate (Tier 6 ONLY):

9a Annual Wage \$ Tier 6 requires employers to determine the Annual Wage for individuals who work Part Time, Seasonal or on an Hourly, Daily or Unit of Work Basis. See the Chart on Page Two for instructions.

Employee Completes Sections 1-3

BSC Completes Sections 4-9a

New Employee Guide

Forms How-To for All New Employees/Transfers



New York State Employee's Retirement Membership Registration Application (RS-5240) - Continued

How do I fill it out (continued)?

- Page 2: Fill out items 10-13
- Question 10: Check yes if you are an active or vested member of any other public retirement system (example: Police and Fire, Teachers Retirement). If you do not know your registration number you may leave that box blank.
- Question 11: Check yes if you are receiving a retirement benefit such as a pension from any employment with New York State or any public entity within the State. If you do not know your registration number you may leave that box blank.
- Question 12: Check yes if you are currently or have ever been a member of the Employee's Retirement System. If you do not know your registration number you may leave that box blank.
- Question 13: List all previous periods of employment with New York State or any New York State public entity (County, City, Town, Village, School District, Public Authority or Special District). Include any military service. Attach additional sheets as required.

How to submit this form:

- Signature required on page 4 - This form does not need to be notarized
- Return to the BSC as soon as possible. Failure to submit within 7 days from the start of new employment will result in employee being required to pay retroactive deductions of contributions.
- By Email: BSCBenefitsAdmin@ogs.ny.gov
- By Fax: 518-457-1879
- By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Sample View: Employees' Retirement System Membership Registration, page 2

Name: _____

Examples of Tier 6 annual wage for individuals paid at an Hourly, Daily or Unit of Work basis of compensation:

Hourly Employees				Daily Employees			
12 month Employee:	\$ _____	x _____	x 260 = \$ _____	12 month Employee:	\$ _____	x _____	x 260 = \$ _____
	Hourly Rate	Standard Workday*	Days Worked		Daily Rate	Days Worked	Annual Wage
10 month Employee:	\$ _____	x _____	x 180 = \$ _____	10 month Employee:	\$ _____	x _____	x 180 = \$ _____
	Hourly Rate	Standard Workday*	Days Worked		Daily Rate	Days Worked	Annual Wage

* Standard Workday (Hrs/day) (Applies to all Tiers): The minimum number of hours that can be established for a standard workday is six, while the maximum is eight. A standard workday is the denominator to be used for the days worked calculation; it is not necessarily the number of hours the person actually worked. For example, if a bus driver works four hours a day, you must still establish a standard workday between six and eight hours as the denominator for their days worked calculation.

Employees		Example: Paid \$50 per Meeting	
_____	x _____ = \$ _____	\$ _____	x _____ = \$ _____
	# of Events**	Unit Rate	# of Events***
	Annual Wage		Annual Wage

***An estimate of the number of events is acceptable

For questions regarding annual wage, please contact the Retirement System.

Are you currently an **active** or **vested** member of **any other** public retirement system in New York State? YES NO

If yes, what is the name of the system? _____

10 REGISTRATION NUMBER (If Known)? _____

WARNING: If you are now an active or vested member of any other public retirement system in New York State, you should contact that system concerning the advantages of transferring your membership to this System. Failure to contact that system could cause loss of the privilege of transferring membership and may effect contribution cessation dates.

Are you receiving or are you about to begin receiving a RETIREMENT BENEFIT from any retirement system on THE BASIS OF EMPLOYMENT with New York State or any public entity in the State? YES NO

11 REGISTRATION NUMBER (If Known)? _____

Have you ever been a member of the New York State Employees' Retirement System? YES NO

12 REGISTRATION NUMBER (If Known)? _____

List below all previous periods of employment with New York State or any New York State public entity (County, City, Town, Village, School District, Public Authority or Special District). Include any military service. Attach additional sheets as required.

13 Name of Employer	Name of Dept. or Agency	Title of Position	From			To			Indicate If Permanent or Temporary, and Full or Part Time
			Mo.	Day	Year	Mo.	Day	Year	

NOTE: In accordance with the Personal Privacy Protection Law you are hereby advised that pursuant to the Retirement and Social Security Law, the Retirement System is required to maintain records. The records are necessary to determine eligibility for and to calculate benefits. Failure to provide information may result in the failure to pay benefits. The System may provide certain information to participating employers. The official responsible maintaining these records is the Director of Member Services, New York State and Local Retirement System, Albany, NY 12244; telephone number 1-866-805-0990.

Employee Completes Items 10 - 13 on Page 2

To Be Completed by the Employee

New Employee Guide

Forms How-To for All New Employees/Transfers



Designation of Beneficiary with Contingent Beneficiaries RS 5127

Download: [Employees' Retirement System \(ERS\) Membership Registration RS-5420 \(Includes RS-5127 Designation of Beneficiary\)](#)

What is this form for? To identify or change beneficiaries.

Is this form mandatory? If you are a new member of the Employee's Retirement System, Yes. If you are already a member of the Employee's Retirement System only complete this form if you would like to change your current beneficiaries. If no beneficiary is elected, your death benefit will go to your estate.

Page 2 RS 5127 instructions continued on the next page.

Sample View: Designation of Beneficiary with Contingent Beneficiaries RS 5127, Page 1

Office of the New York State Comptroller
New York State and Local Retirement System
Employees' Retirement System
Police and Fire Retirement System
110 State Street, Albany, New York 12244-0001

For Office Use Only

Receipt Date

Designation of Beneficiary With Contingent Beneficiaries

RS 5127

(Rev. 9/14)

THIS FORM MUST BE SIGNED, NOTARIZED AND FILED WITH THE RETIREMENT SYSTEM PRIOR TO YOUR DEATH TO BE EFFECTIVE.

Please **PRINT** clearly, using only blue or black ink.

Member/Pensioner Information

Registration/Retirement Number: _____ Last 4 Digits of Social Security Number* _____

Name: _____ Former Name: _____

Home Address: _____

City, State, Zip Code: _____ Date of Birth: _____

Telephone Number: _____ Email Address: _____

Employed By: _____	Employer Address: _____
--------------------	-------------------------

IMPORTANT INFORMATION REGARDING THIS FORM

- If you find this form is not suited to the type of designation you prefer please advise the Retirement System. In the meantime, for your protection and the protection of your beneficiary(ies), you should make an interim designation using this form. If you wish to designate more beneficiaries than this form allows or to designate a Trust, Guardianship or payment under the Uniform Transfers to Minors Act please contact the Retirement System for the appropriate form.
- Attachments to your beneficiary form are **unacceptable**.
- New beneficiary forms filed will supersede any previous designation. Therefore, if you want to **add** or **delete** a beneficiary, for example a new child, you must include on the new form **all** beneficiaries you wish to designate.
- The same person or persons cannot be designated as both primary and contingent beneficiaries. We make payment to a contingent beneficiary(ies) only if **all** primary beneficiary(ies) die before you do.
- If you wish to have these benefits distributed through your estate, you should name "my estate" as beneficiary. Your estate can be named as either primary or contingent beneficiary. However, if you name your estate as primary beneficiary, you may not name any contingent beneficiary.
- This form is for designating beneficiaries to receive your ordinary death or post retirement death benefit. You may not designate beneficiaries to receive accidental death benefits. The beneficiaries entitled to receive accidental death benefits are mandated by statute.

Make sure that you:

- Complete all requested information.
- Sign and date the form.
- Have the form notarized, making sure the notary has entered the date his or her commission expires.
- Mail your completed form to:
**New York State and Local Retirement System
Member & Employer Services
Registration – Mail Drop 5-6
110 State Street
Albany, NY 12244-0001**

PERSONAL PRIVACY PROTECTION LAW
In accordance with the Personal Privacy Protection Law you are hereby advised that pursuant to the Retirement and Social Security Law, the Retirement System is required to maintain records. The records are necessary to determine eligibility for and to calculate benefits. Failure to provide information may result in the System's inability to pay benefits the way you prefer. The System may provide certain information to participating employers. The official responsible for maintaining these records is the Director of Member & Employer Services, New York State and Local Retirement Systems, Albany, NY 12244. For questions concerning this form, please call 1-866-805-0990 or 518-474-7736.

***SOCIAL SECURITY DISCLOSURE REQUIREMENT**
In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of the Social Security Account Number is mandatory pursuant to sections 11, 31, 34 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

Please go to the reverse side of this form to designate beneficiaries, sign and date the form, and have the form notarized.

RS 5127 (front)

Employee
Enters
Member/
Pensioner
Information



New Employee Guide

Forms How-To for All New Employees/Transfers



Designation of Beneficiary with Contingent Beneficiaries RS 5127 - Continued

How to submit this form:

- Only the original, signed hard copy of this form is accepted
- Signature required / Notarization Required
- Return to the BSC as soon as possible
- By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Sample View: Designation of Beneficiary with Contingent Beneficiaries RS 5127, Page 2

Employee Identifies Primary Beneficiaries



Employee Identifies Contingent Beneficiaries



Employee Signature Required



Notarization Required



Do not alter this form or make stipulations. The use of correction fluid or other alterations on this form will render the designation invalid.

To the Comptroller of the State of New York.

Designation of Primary Beneficiary(ies). I hereby name the following beneficiary(ies) to receive any ordinary death or post retirement death benefit, payable on my behalf. If I have named more than one beneficiary, it is my intention that those living at the time of my death should share equally any benefit payable. I reserve the right to change this designation at any time.

Name <input type="checkbox"/> Male <input type="checkbox"/> Female	Name <input type="checkbox"/> Male <input type="checkbox"/> Female
Address	Address
Relationship Birth Date	Relationship Birth Date
Telephone Number	Telephone Number
Name <input type="checkbox"/> Male <input type="checkbox"/> Female	Name <input type="checkbox"/> Male <input type="checkbox"/> Female
Address	Address
Relationship Birth Date	Relationship Birth Date
Telephone Number	Telephone Number
Name <input type="checkbox"/> Male <input type="checkbox"/> Female	Name <input type="checkbox"/> Male <input type="checkbox"/> Female
Address	Address
Relationship Birth Date	Relationship Birth Date
Telephone Number	Telephone Number

Designation of Contingent Beneficiary(ies). If all of the designated primary beneficiaries die before I do, any ordinary death or post retirement death benefit payable on my behalf shall be paid to the following. If I have named more than one beneficiary, it is my intention that those living at the time of my death should share equally any benefit payable. If I out-live all of these contingent beneficiaries, any benefit payable should be paid to my estate. I reserve the right to change this designation at any time.

Name <input type="checkbox"/> Male <input type="checkbox"/> Female	Name <input type="checkbox"/> Male <input type="checkbox"/> Female
Address	Address
Relationship Birth Date	Relationship Birth Date
Telephone Number	Telephone Number
Name <input type="checkbox"/> Male <input type="checkbox"/> Female	Name <input type="checkbox"/> Male <input type="checkbox"/> Female
Address	Address
Relationship Birth Date	Relationship Birth Date
Telephone Number	Telephone Number

This form must be signed, dated and notarized in order to be valid

Member/Pensioner Signature _____ Date _____

Acknowledgement To Be Completed by a Notary Public

State of _____ County of _____

On the ____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Notary Public Stamp

NOTARY PUBLIC (Please sign and affix stamp)

RS 5127 (Rev. 9/14)
reverse

New Employee Guide

Forms How-To for All New Employees/Transfers

Declination of Membership in the New York State Employee Retirement System

Download: [Declination of Membership in the New York State Retirement System](#)

What is this form for? If you are a temporary, part-time or provisional employee, you may decline membership in the ERS. This form formally declares your option to not enroll in the ERS.

Is this form mandatory? No. However, if you are a temporary, part-time or provisional employee, and choosing to decline membership, you must submit this form.

How do I fill it out?

- Download the form.
- This form is fillable. Complete the form by typing in your information in each of the fields.
- This form requires your signature — print out the form and sign it.

How to submit this form:

-  Signature Required
-  Return within 30 days of your start date
-  By Email: BSCBenefitsAdmin@ogs.ny.gov
-  By Fax: 518-457-1879
-  By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Sample View: Declination of Membership in the NYS Employee Retirement System

**Office of
General Services** | **Business
Services Center**

Declination of Membership in the New York State Employee Retirement System

Employee Name

Agency Code Employee ID Number

Type of Appointment:
 Part-Time Temporary Provisional Less than 12 Months

I have received a copy of the current New York State Employee Retirement System publication describing the retirement plan. I am aware of the benefits available under this contributory plan and my right to membership in the New York State Employee Retirement System.

I do not wish to enroll in the New York State Employee Retirement System at this time.

Employee Signature _____ Date

Employee Signature 

Please sign and return this form to BSC:

BSC Benefits Unit
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900
BSCPayrollAdmin@ogs.ny.gov
518-457-4272

New Employee Guide

Forms How-To for All New Employees/Transfers

New York State Health Insurance Transaction Form (PS-404)

Download: [New York State Health Insurance Transaction Form \(PS-404\)](#)

What is this form for? To enroll in NYSHIP or to change benefits.

How does NYSHIP work? The cost for health insurance is deducted from the employee's bi-weekly paycheck. Employees may select the Empire Plan or one of many participating Health Maintenance Organizations. Depending on your negotiating unit, there is a specific waiting period for health insurance to take effect. Health insurance premiums are deducted from employee's paychecks 2 pay periods (28 days) prior to the effective date of coverage. If you leave state service, your health insurance coverage continues for 28 days from the last day of the last pay period in which you work. To avoid having to pay retroactive premiums to cover the 2 pay periods prior to the start of coverage becoming effective, please submit the completed PS-404 with all required proofs as soon as possible at the start of your employment.

- For CSEA employees: 42-day waiting period. Enrollment after 42 days will result in a 5-pay period waiting period before such coverage becomes effective and health insurance contributions being deducted on a post-tax basis.
- For PEF employees: 56-day waiting period. Enrollment after 56 days will result in a 5-pay period waiting period before such coverage becomes effective and health insurance contributions being deducted on a post-tax basis.
- For M/C Employees: 56-day waiting period. Enrollment after 56 days will result in a 5-pay period waiting period before such coverage becomes effective and health insurance contributions being deducted on a post-tax basis.

Is this form mandatory? Yes. Even if you intend to decline coverage, all employees must complete this form. In addition, employees who have other employer sponsored group health insurance may choose to opt-out of the health insurance coverage in exchange for an incentive payment.

How do I fill it out?

- Download the form.
- This form is fillable. Complete the form by typing in your information in each of the fields. See additional instructions to the right.
- This form requires your signature on page 2. You must print out the form and sign it. Copies of proof documentation must be provided for you, the employee, and all your eligible dependents.

How to submit this form:

Signature Required

Refer to your Employee Enrollment Deadlines sheet for your enrollment deadline, based on bargaining unit

By Email: BSCBenefitsAdmin@ogs.ny.gov

By Fax: 518-457-1879

By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Sample: NYS Health Insurance Transaction Form (PS-404), page 1

NEW YORK STATE OF OPPORTUNITY		Department of Civil Service		EMPLOYEE BENEFITS DIVISION NYS HEALTH INSURANCE TRANSACTION FORM PS-404 (9/16)				
INSTRUCTIONS: READ AND COMPLETE BOTH SIDES/PAGES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.								
EMPLOYEE INFORMATION <small>(All employees must complete)</small>								
1. Last Name		First Name	MI	2. Social Security Number				
3. Sex		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female						
4. Street Address		City		State	Zip			
5. Date of Birth		6. Telephone Numbers		7. Work location and address				
		Primary () Work ()						
8. Marital Status		Marital Status Date						
<input type="checkbox"/> Single <input type="checkbox"/> Widowed		<input type="checkbox"/> Divorced <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		Child: <input type="checkbox"/> Yes <input type="checkbox"/> No				
10. DEPENDENT INFORMATION								
Must be provided when choosing to enroll or opt-out of NYSHIP family coverage (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)								
Date of Event _____								
	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								
11. NEW OR NEWLY ELIGIBLE EMPLOYEES: CHOOSE ONE OF THE FOLLOWING OPTIONS (A, B OR C)								
A. Enroll in NYSHIP Coverage: Choose options 1 or 2 and complete box 3								
1. Individual Enrollment		Medical (10) (Select Empire Plan or HMO)		<input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14)				
		<input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code [] Name []						
2. Family Enrollment		Medical (10) (Select Empire Plan or HMO)		<input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14)				
(Complete box 10)		<input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code [] Name []						
3. <input type="checkbox"/> Elect Pre-Tax Status for Premium deduction		<input type="checkbox"/> Elect Post-Tax Status for Premium deduction						
<small>Please read the Pre-Tax Contribution program materials.</small>								
B. Elect the Opt-out program (if eligible): Complete boxes 1 and 2								
1. <input type="checkbox"/> Individual Opt-out <input type="checkbox"/> Family Opt-out		If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.						
2. <input type="checkbox"/> Elect Pre-Tax Status for Premium deduction		<input type="checkbox"/> Elect Post-Tax Status for Premium deduction						
<small>Please read the Pre-Tax Contribution program materials.</small>								
C. Decline NYSHIP Coverage <input type="checkbox"/> Medical (10) <input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14)								
12. TO CHANGE OR CANCEL COVERAGE CHOOSE FROM THE BOXES BELOW								
A. Change Coverage:		<input type="checkbox"/> Medical (10) <input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14)		Date of Event: _____				
<input type="checkbox"/> Change to FAMILY (Complete box 10)		<input type="checkbox"/> Change to INDIVIDUAL						
<input type="checkbox"/> Marriage		<input type="checkbox"/> Divorce						
<input type="checkbox"/> Domestic Partner		<input type="checkbox"/> Termination of Domestic Partnership (Attach completed PS-425.4)						
<input type="checkbox"/> Newborn		<input type="checkbox"/> Only dependent ineligible due to age						
<input type="checkbox"/> Request coverage for dependents not previously covered		<input type="checkbox"/> I voluntarily cancel coverage for my dependents						
<input type="checkbox"/> Previous coverage terminated (proof required)		<input type="checkbox"/> Only dependent died						
<input type="checkbox"/> Dependent returned to full-time student status		<input type="checkbox"/> Only dependent married (Dental and Vision only)						
(Dental and Vision only)		<input type="checkbox"/> Only dependent graduated (Dental and Vision only)						
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____						
B. Voluntarily Cancel Coverage: <input type="checkbox"/> Medical (10) <input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14) Qualifying Event:								
<small>NOTE: If you are enrolled in the Pre-Tax Contribution Program, your ability to make mid-year changes may be</small>								

Employee Completes #1-9 Under Employee Information



Employee Completes #10 as either A or B to elect enrollment; or D to elect the opt-out; or E to decline coverage.



For family coverage, employee completes Dependent Information. Appropriate proofs must be provided to add dependents.

On page 2 (not shown), employees must sign and date this form.

New Employee Guide

Forms How-To for All New Employees/Transfers



NYSHIP Opt-Out Attestation Form (PS-409)

Download: [Opt-Out Attestation Form \(PS-409\)](#)

What is this form for? To enroll in the NYSHIP Opt-Out Program. Eligible employees who attest to having other employer-sponsored group health insurance (other than New York State insurance) may elect to opt out of NYSHIP coverage in exchange for an incentive payment, currently \$1,000 for Individual Opt-Out (\$38.47 over 26 bi-weekly paychecks) or \$3,000 for Family Opt-Out (\$115.39 over 26 bi-weekly paychecks).

Is this form mandatory? No. Only if you are eligible and wish to enroll in the Opt-Out program.

How do I enroll? To participate, employees must submit:

- A completed PS-404 Health Insurance Transaction Form.
- [PS-409 Opt-Out Attestation Form](#) - Employee completes entire form.

These forms must be received by the BSC Benefits Unit by the first date of eligibility. Any request to enroll in the Opt-Out Program made after the first date of eligibility will not be honored. Furthermore, eligibility for Opt-Out in subsequent years may also be impacted. The following are deadlines for each bargaining unit:

- For CSEA employees: Opt-out forms must be submitted within the 42-day waiting period in order to qualify for the incentive payments.
- For PEF employees: Opt-out forms must be submitted within the 56-day waiting period in order to qualify for the incentive payment.
- For M/C employees: Opt-out forms must be submitted within the 56-day waiting period in order to qualify for the incentive payment.

How do I fill out the form?

- Download the form.
- This form is fillable. Complete the entire form by typing in your information in each of the fields.
- This form requires your signature — print out the form and sign it.

How to submit this form:

- Signature Required
- Refer to your Employee Enrollment Deadlines sheet for your enrollment deadline, based on bargaining unit
- By Email: BSCBenefitsAdmin@ogs.ny.gov
- By Fax: 518-457-1879
- By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Sample View: Opt-Out Attestation Form (PS-409)

NEW YORK STATE OF OPPORTUNITY		Department of Civil Service	EMPLOYEE BENEFITS DIVISION OPT-OUT PROGRAM ATTESTATION FORM
			PS-409 (11/15)
EMPLOYEE INFORMATION			
Name		Social Security Number	Negotiating Unit
Street Address		City	State Zip
Date of Birth	Telephone Numbers Home () Work ()		Agency Name and Address
Marital Status <input type="checkbox"/> Single	<input type="checkbox"/> Married <input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
NYSHIP HEALTH BENEFITS OPT-OUT ELECTION			
You must attest to having other employer-sponsored group health insurance to be eligible for the Opt-out Program. Other employer-sponsored group health coverage cannot be :			
<ul style="list-style-type: none"> • The result of your or your spouse's, domestic partner's or parent's employment relationship with NYS, or • The result of your own employment with a NYSHIP Participating Agency (PA) or Participating Employer (PE) 			
If you are eligible to Opt-out, please check one:			
I have other coverage as a dependent		I have other coverage through my own employment	
<input type="checkbox"/>	My other coverage is not NYSHIP coverage. I am electing to Opt-out of Individual coverage in exchange for a \$1,000 taxable payment (\$38.47 over 26 biweekly paychecks).	<input type="checkbox"/>	My other coverage is not NYSHIP coverage. I am electing to Opt-out of Individual coverage in exchange for a \$1,000 taxable payment (\$38.47 over 26 biweekly paychecks).
<input type="checkbox"/>	My other coverage is not NYSHIP coverage. I am electing to Opt-out of Family coverage in exchange for a \$3,000 taxable payment (\$115.39 over 26 biweekly paychecks).	<input type="checkbox"/>	My other coverage is not NYSHIP coverage. I am electing to Opt-out of Family coverage in exchange for a \$3,000 taxable payment (\$115.39 over 26 biweekly paychecks).
<input type="checkbox"/>	My other coverage is NYSHIP through an employer other than New York State. I understand that I am only eligible to Opt-out of Individual coverage in exchange for a \$1,000 taxable payment (\$38.47 over 26 biweekly paychecks).	<input type="checkbox"/>	My other coverage is not NYSHIP coverage. I am electing to Opt-out of Family coverage in exchange for a \$3,000 taxable payment (\$115.39 over 26 biweekly paychecks).
Other employer-sponsored group health insurance information must be provided as indicated below:			
Name of covered employee _____		Covered employee's Date of Birth _____	
Covered employee's SSN _____			
Name of covered employee's employer _____		Effective date of other group health insurance coverage _____	
Name and Address of alternate health insurance coverage _____			
<small>(You must provide either a copy of your health insurance card or a letter from your employer or other health insurance provider confirming current coverage).</small>			
ATTESTATION			
I have read the Opt-out Program materials and instructions and I attest to the following:			
<ul style="list-style-type: none"> • I meet the qualifications to elect the Health Insurance Opt-out Program. • I understand that I must promptly report changes that may impact my eligibility or payment amount (e.g., loss of other employer-sponsored coverage, divorce, death, last dependent loses eligibility for NYSHIP coverage) if I fail to do so, I am responsible for any Opt-out Program payments made to me in error. I understand that Opt-out Program payments made to me in error may be recovered as special deductions of up to \$200 from my biweekly paycheck. • I understand that I may choose to opt out of Family coverage only if I have NYSHIP eligible dependents and I am not enrolled in NYSHIP as a dependent or enrollee through NYS or another NYSHIP employer, and that I must provide proof of my dependent's eligibility when enrolling each year. • I understand that this election is for only one plan year. I must submit the PS-404 and PS-409 again during the next Option Transfer Period if I am eligible and choose to continue in the Opt-out Program. 			
Employee's Signature (Required) _____		Signature Date (Required) _____	
HBA's Signature (Required) _____		Signature Date (Required) _____	

Employee Signature



New Employee Guide

Forms How-To for All New Employees/Transfers

Veterans Identification Form

Download: [Veterans Identification Form](#)

What is this form for? This form is used for employees to identify that they are a Veteran of the Armed Forces of the United States. Certain Veterans may be eligible for additional benefits by completing this form and submitting appropriate documentation to the BSC.

Is this form mandatory? No.

How do I fill out the form?

- Print and complete the form.
- This form requires supporting documentation.
- This form requires your signature.

How to submit this form:

 Signature Required

 Attach Documentation

 By Email: BSCBenefitsAdmin@ogs.ny.gov

 By Fax: 518-457-1879

 By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Sample View: Veteran's Identification Form

NYS Business Services Center Personnel Services Unit 1220 Washington Avenue Building #5 Harriman State Campus Albany, New York 12226		VETERAN'S IDENTIFICATION FORM	
Employee Name (First, Middle Initial, Last)		Last 4 Digits of SS#	Date of Birth
Title		Work Address	
Work Telephone Number		Item Number	
<p>HONORABLE DISCHARGE: Did you receive an Honorable Discharge or release under honorable circumstances from the Armed Forces of the United States? The Armed Forces of the United States means the Army, Navy, Marine Corps, Air Force, and Coast Guard, including all components thereof and the National Guard when in the service of the United States pursuant to call as provided by Law on a full-time duty basis other than active duty for training purposes:</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>CREDITS FOR EXAMS/SENIORITY</p> <p><input type="checkbox"/> Disabled Veteran <input type="checkbox"/> Non-disabled Veteran</p>			
<p>DATES OF SERVICE: Did you have active service during any of the following periods? (Check all that apply)</p> <p><input type="checkbox"/> December 7, 1941 to December 31, 1946 <input type="checkbox"/> For hostilities in Lebanon: June 1, 1983 to December 1, 1987</p> <p><input type="checkbox"/> June 27, 1950 to January 31, 1955 <input type="checkbox"/> For hostilities in Panama: December 20, 1989 to January 31, 1990</p> <p><input type="checkbox"/> December 22, 1961 to May 7, 1975 <input type="checkbox"/> For Persian Gulf Conflict: August 2, 1990 to date hostilities ended</p> <p><input type="checkbox"/> For hostilities in Grenada: October 23, 1983 to November 21, 1983 <input type="checkbox"/> U.S. Public Health Services from July 29, 1945 to September 2, 1945 or from June 26, 1950 to July 3, 1952</p>			
<p>ACCEPTABLE DOCUMENTARY PROOF: Report of Separation and Honorable Discharge and/or Certificate of Service. Acceptable military forms NAVPERS-553; NAVMC-78; WDAGO-53, 55; WDAGO 53, 98; AND DD-214. The Armed Forces expeditionary medal, the Navy expeditionary medal, or the Marine Corps expeditionary medal is required to qualify for veterans' status for hostilities in Grenada, Lebanon and Panama. If name is different from that shown on Report of Separation and Honorable Discharge, legal documentation to verify the name change is required.</p> <p>Military Form Attached: _____</p> <p>Other Legal Documents Attached: _____</p>			
<p>Acceptable Documentation </p>		<p>Employee Signature </p>	
		Signature	Date
<p>SEND COPY OF FORM TO:</p>		<p>NYS Business Services Center Personnel Services Unit 1220 Washington Avenue Building #5 Harriman State Campus Albany, New York 12226</p>	
<p>(Rev 6/15)</p>			

New Employee Guide

Forms How-To for All New Employees/Transfers

Getting Paid

New employees are subject to the state's salary withholding program. As part of this program, 7.5 hours (for employees working 37.5 hour weeks) or 8 hours (for employees working 40 hour weeks) of pay will be withheld from each of an employee's first 5 paychecks. Employee's will be paid back for this time when they leave State service at whatever rate of pay they are making at that time.

Most New York State employees are paid on a "lag" basis; therefore, you will not receive your first paycheck until two weeks following the last day of the first pay period of your employment (i.e. two weeks from the day that your first time sheet period ends).

W-4: Federal Withholding Certificate

Download: [W-4 Federal Withholding Certificate](#)

What is this form for? To identify and withhold the correct federal income tax from your pay.

Is this form mandatory? Yes. If you do not complete this form, your withholdings default to "single" and "0." Withholding elections for employees who transferred from another state agency will transfer with the employee from their former agency. Employees should complete this form to make changes to their withholdings.

How do I fill out the form?

- Download the form.
- This form is fillable. Complete the entire form by typing in your information in each of the fields.
- This form requires your signature — print out the form and sign it.

How to submit this form:

Signature Required

By Email: BSCBenefitsAdmin@ogs.ny.gov

By Fax: 518-457-1879

By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Sample View: W-4 Federal Employee's Withholding Allowance Certificate

Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4R.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent **A** _____

B Enter "1" if:
{

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.
} **B** _____

C Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) **E** _____

F Enter "1" if you have at least \$2,000 of **child or dependent care expenses** for which you plan to claim a credit (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) **F** _____

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
 • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children.
 • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child **G** _____

H Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ► **H** _____

For accuracy, complete all worksheets that apply.
{

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.
}

----- Separate here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	Employee's Withholding Allowance Certificate ► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.	OMB No. 1545-0074 2016
1 Your first name and middle initial _____ Last name _____	2 Your social security number _____	
Home address (number and street or rural route) _____		
City or town, state, and ZIP code _____		
3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withheld at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) _____		6 \$ _____
6 Additional amount, if any, you want withheld from each paycheck _____ I claim exemption from withholding for 2016, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability , and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability . If you meet both conditions, write "Exempt" here ► 7 _____		
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) ► _____		Date ► _____
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) _____		9 Office code (optional) _____
10 Employer identification number (EIN) _____		

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form W-4 (2016)

Employee Signature



New Employee Guide

Forms How-To for All New Employees/Transfers

IT-2104: New York State Withholding Certificate

Download: [IT-2014: New York State Withholding Certificate](#)

What is this form for? To identify and withhold the correct New York State, New York City and/or Yonkers tax.

Is this form mandatory? Yes. If you do not complete this form, your withholdings default to “single” and “1.” Withholding elections for employees who transferred from another state agency will transfer with the employee from their former agency. Employees should complete this form to make changes to their withholdings.

How do I fill out the form?

- Download the form.
- This form is fillable. Complete the entire form by typing in your information in each of the fields.
- This form requires your signature — print out the form and sign it.

How to submit this form:

 Signature Required

@ By Email: BSCBenefitsAdmin@ogs.ny.gov

 By Fax: 518-457-1879

 By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Sample View: IT-2104: New York State Withholding Certificate



Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial	Last name	Your social security number
Permanent home address (number and street or rural route)		Apartment number
City, village, or post office		State ZIP code

Are you a resident of New York City? Yes No
 Are you a resident of Yonkers? Yes No

Complete the worksheet on page 3 before making any entries.

1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 17)	1
2 Total number of allowances for New York City (from line 28)	2

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3 New York State amount	3
4 New York City amount	4
5 Yonkers amount	5

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date
----------------------	------

Penalty – A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an **X** in box A and/or box B to indicate why you are sending a copy of this form to New York State (see instructions):

A Employee claimed more than 14 exemption allowances for NYS A

B Employee is a new hire or a rehire ... B First date employee performed services for pay (mm-dd-yyyy) (see instr.):

Are dependent health insurance benefits available for this employee? Yes No

If Yes, enter the date the employee qualifies (mm-dd-yyyy):

Employer's name and address (Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)	Employer identification number
--	--------------------------------

Instructions

Changes effective for 2016

Form IT-2104 has been revised for tax year 2016. The worksheet on page 3 and the charts beginning on page 4, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2016 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If you do not file Form IT-2104, your employer may use the same number of allowances you claimed on federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers. Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim

is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn \$106,950 or more during the tax year.
- The total income of you and your spouse has increased to \$106,950 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.

Employee Signature



New Employee Guide

Forms How-To for All New Employees/Transfers

Direct Deposit Form for NYS Employees

Download: [Direct Deposit Form for NYS Employees](#)

What is this form for? For direct deposit enrollment, changes and cancellations.

Is this form mandatory? No. Direct deposit is optional for state employees. If you want your paycheck, or a portion of it, directly deposited into your bank account, you must complete this form. If you are an employee who transferred from another state agency, your direct deposit transfers with you.

How do I fill out the form?

- Download the form.
- This form is fillable. Complete the form by typing in your information in each of the fields.
- Your NYS EMPLID can be found on your New Employee Checklist.
- Section C: Either attach a voided check from the account(s) you are adding, or your financial institution must fill-out.
- This form requires your signature — print out the form and sign it.

How to submit this form:

 Signature Required

 Attachments required if submitting voided check(s)

 By Email: BSCBenefitsAdmin@ogs.ny.gov

 By Fax: 518-457-1879

 By Mail: BSC Benefits Administration
W. Averell Harriman State Office Campus
1220 Washington Avenue
Building 5, Floor 4
Albany, NY 12226-1900

Employee completes Section A; EMPLID is located on your Employee Checklist

Employee completes Section B

Employee attaches voided check(s) or financial institution completes Section C

Employee & Additional Account Holders Signature

Sample View: Direct Deposit Form for NYS Employees

AC 2772 (Rev. 11/12) PLEASE SEE REVERSE SIDE FOR INSTRUCTIONS

Direct Deposit Form for NYS Employees

(To be used for enrollment, changes and cancellations)

Section A: Employee Information
NAME (LAST, FIRST, MI) _____ WORK PHONE # (____) _____
NYS EMPLID # N _____ AGENCY/DEPT CODE _____

For more than three accounts or if you prefer to list each Financial Institution on a separate form, use additional forms as necessary. Up to seven fixed amount or percentage deposits may be processed as well as one excess (net pay) deposit.

Section B: Account Type	New or Additional *	Change Joint Account Holder *	Change Amount or Percentage	Cancel	Name of Financial Institution	Account Number	Amount, Percentage or Excess
1. <input type="checkbox"/> Savings <input type="checkbox"/> Checking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2. <input type="checkbox"/> Savings <input type="checkbox"/> Checking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3. <input type="checkbox"/> Savings <input type="checkbox"/> Checking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

*For new/additional accounts with joint account holders or to add a joint account holder to existing accounts, both signatures are required in Section D.

Section C: This section must be completed by your financial institution for new/additional accounts when directing funds into a savings account or into a checking account if a voided personal check is not attached. The employee's name MUST appear on the account(s).
As a representative of the below named financial institution, I certify that this institution is ACH capable and agree to receive and deposit the salary to the account shown above in accordance with Part 102 of the Codes, Rules, and Regulations of the State of New York and to be bound by such rules. Salary credited to the account below will be available to the depositor on payday.

1. NAME OF FINANCIAL INSTITUTION _____ Account Type Savings Checking
Depositor's Account Number (EFT Format) _____ Routing Number _____
Print or Type Representative's Name _____ Signature of Representative _____ Telephone Number _____ Date _____

2. NAME OF FINANCIAL INSTITUTION _____ Account Type Savings Checking
Depositor's Account Number (EFT Format) _____ Routing Number _____
Print or Type Representative's Name _____ Signature of Representative _____ Telephone Number _____ Date _____

3. NAME OF FINANCIAL INSTITUTION _____ Account Type Savings Checking
Depositor's Account Number (EFT Format) _____ Routing Number _____
Print or Type Representative's Name _____ Signature of Representative _____ Telephone Number _____ Date _____

Section D: Employee/Joint Account Holders Certification: I certify that I read and understand the instructions to this form, including the authorization for recovery. In signing this form, I authorize my salary payment to be sent to the designated financial institution(s) to be deposited into the specified account(s). The joint account holder for accounts listed in Section B, if any, must sign on the corresponding line for new/additional accounts or account holder(s).

Employee Signature _____ Date _____
B-1 Joint Account Holder _____ Date _____
B-2 Joint Account Holder _____ Date _____
B-3 Joint Account Holder _____ Date _____

This form is a legal document and cannot be altered by the agency, employee or financial institution. If there are any changes, the employee must complete a new form.

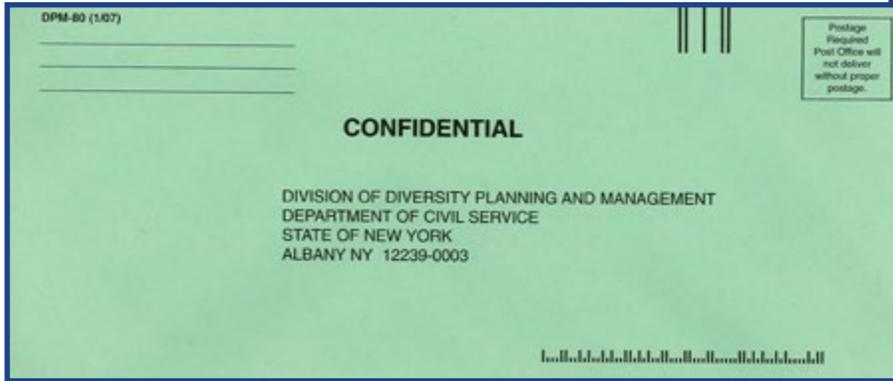
New Employee Guide

Forms How-To for All New Employees/Transfers



Civil Service NYS Self-Identification of Employee Disability Status

Your agency HR representative will provide you with a copy of this form for completion, complete with a postage-paid, self-addressed envelope. Return the form in the envelope provided.



Sample View: Civil Service NYS Self-Identification of Employee Disability Status

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

DPM-100(12/12L) MASTER AFFIRMATIVE ACTION DATA COLLECTION FORM

This information is being collected pursuant to Title VII of the Civil Rights Act of 1964, as amended, and Executive Order No. 6, for the principal purpose of complying with the obligation to collect and report workforce data. The information that you provide will be kept confidential and will only be released in accordance with Section 86(1) of the Personal Privacy Protection Law, particularly subdivisions (a), (a) and (f), in a summary statistical form. You are requested to provide this information on a voluntary basis and failure to provide the information will not affect your employment. This information will be maintained by the Department of Civil Service, Albany, New York 12239. For further information concerning the Personal Privacy Protection Law, call (518) 457-9375. For information or questions regarding this form, please contact the Division of Staffing Services at (518) 473-6437.

INSTRUCTIONS FOR PERSONNEL OFFICERS:

- This form must be given to every new hire in an agency work force. New hires include individuals reentering State service, as well as individuals moving from one agency to another. Provide original forms only. Do not provide copies. This document will be electronically scanned.
- Prior to providing this form to the new hire, enter your agency's five digit code in the space provided on the form. Please be sure to fill in the corresponding circle below each digit in your agency's code.
- Provide the new hire with appropriate pre-addressed envelope (DPM-80) to ensure proper transmittal of the form to the Department of Civil Service. Please inform new hires that the form must be completed using a No. 2 pencil.

FOLD HERE

INSTRUCTIONS FOR EMPLOYEES:

- Do not make any stray marks or smudges on either side of this questionnaire.
- Completely erase any marks you want to change.
- Completely fill in the circle with dark pencil marks (use only a No. 2 pencil).

EXAMPLE: ● CORRECT ○ WRONG ○ WRONG

—Fold the form along the dotted lines, place it in the pre-addressed envelope provided, SEAL THE ENVELOPE, and return it to the Personnel Officer.

—If you have difficulty completing this form, contact your Affirmative Action Officer.

AGENCY CODE

Write Agency Code Here →

1	2	3	4	5
○	○	○	○	○
○	○	○	○	○
○	○	○	○	○
○	○	○	○	○
○	○	○	○	○
○	○	○	○	○
○	○	○	○	○
○	○	○	○	○
○	○	○	○	○
○	○	○	○	○

Fill in the Corresponding Circle Below Each Number Appearing On The Column Head

SOCIAL SECURITY CODE

Write Your Social Security Number Here →

1	2	3	4	5	6	7	8	9	0
○	○	○	○	○	○	○	○	○	○
○	○	○	○	○	○	○	○	○	○
○	○	○	○	○	○	○	○	○	○
○	○	○	○	○	○	○	○	○	○
○	○	○	○	○	○	○	○	○	○
○	○	○	○	○	○	○	○	○	○
○	○	○	○	○	○	○	○	○	○
○	○	○	○	○	○	○	○	○	○
○	○	○	○	○	○	○	○	○	○
○	○	○	○	○	○	○	○	○	○

Fill in the Corresponding Circle Below Each Number Appearing On The Column Head

DATE

Write Today's Date Here →

Month	Day	Year
○	○	○
○	○	○
○	○	○
○	○	○
○	○	○
○	○	○
○	○	○
○	○	○
○	○	○
○	○	○

Fill in the Corresponding Circle Below Each Number Appearing On The Column Head

FILL IN THE ONE CIRCLE THAT DESCRIBES YOU:

- WHITE (not of Hispanic origin)—A person having origins in any of the original peoples of Europe, North Africa or the Middle East.
- BLACK (not of Hispanic origin)—A person having origins in any of the Black racial groups of Africa.
- HISPANIC—A person of Puerto Rican, Mexican, Cuban, Dominican, Central or South American, or other Spanish culture or origin, regardless of race.
- ASIAN OR PACIFIC ISLANDER—A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.
- AMERICAN INDIAN OR ALASKAN NATIVE—A person having origins in any of the original peoples of North America and who maintains tribal affiliation or community recognition.

FILL IN THE CIRCLE THAT DESCRIBES YOUR GENDER:

MALE
 FEMALE

VIETNAM ERA VETERAN STATUS: For affirmative action purposes, a Vietnam Era Veteran is any person who served as a member of the Armed Forces of the United States on full-time active duty, other than for training purposes, any part of which occurred between February 28, 1961, and May 7, 1975, and was honorably discharged or released under honorable circumstances.

Are you a Vietnam Era Veteran as defined? NO YES

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New Employee Guide

Information for PEF Members Only



Public Employee Federation (PEF) Membership Application

Download: [PEF Membership Application](#)

What is this form for? To become a PEF member and receive PEF membership benefits. PEF membership will transfer with transferred employees who are already PEF members.

Is this form mandatory? No. If you are a PEF-represented employee, union dues will automatically be deducted from your paychecks. You are not required to join the union, however, you cannot enroll in PEF benefits if you do not join the union.

How do I fill out the form? Employees must:

- Print and complete the form.
- This form requires your signature.

Where do I submit this form? Mail the signed form to:

PEF
1168-70 Troy Schenectady Road
PO Box 12414
Albany, NY 12212-2414

PEF Vision Plan Information

About: Vision insurance is paid for by the state or negotiating unit and is free for active employees and their families. Vision insurance provided by Davis Vision with a 56-day waiting period

How to Enroll: Use the [PS-404 Health Insurance Transaction form](#)

Learn More: [NYS Vision Plan for NYS Employees Represented by PEF](#), 1-888-588-4823

PEF Dental Plan Information

About: Dental coverage is paid for by the state or negotiating unit and is free for active employees and their families. Dental coverage provided by Emblem Health with a 56-day waiting period

How to Enroll: Use the [PS-404 Health Insurance Transaction form](#)

Learn More: [PEF Dental Plan](#), Emblem Health 1-800-947-0101

PEF Disability & Term Life Insurance

About: Available through PEF membership benefits.

Learn More: <https://www.buymbp.com/>

Sample View: PEF Membership Application and Dues Payroll Deduction Authorization

**New York State Public Employees Federation, AFL-CIO**
PEF MEMBERSHIP APPLICATION and
DUES PAYROLL DEDUCTION AUTHORIZATION

TO BECOME A MEMBER ...
Complete this application form and mail it in the enclosed business reply envelope.

Please print LEGIBLY: _____
Last Name First Name M.I.

First Line Street Address Second Line Street Address

City State Zip Code
() - () - /

Home Telephone No. Work Telephone No. Date of Birth (MM / DD / YYYY)

PEF Online Information

- Get valuable updates via email or text message
- **IMPORTANT:** Personal emails are required due to New York State restrictions on the use of work emails.

Email Address (please print) _____@_____

Phone for Text: () _____ - _____ (Note: Texting fees may apply)

By providing the information above, you are giving PEF and PEF Membership Benefits Program (PEF MBP) permission to contact you regarding PEF union notices (e.g., PEF ON THE MOVE which provides notices on contract benefits/benefit changes, issues affecting terms and conditions of employment, contract negotiations, as well as PEF MBP benefit updates). You can opt-out of these at any time.

- How would you like to receive *THE COMMUNICATOR* – PEF’s in-house publication? (choose one)

Online version by email notification
 Printed magazine sent to your home address

You can apply online @ www.pef.org/join-pef/

OR you can send this form by

Fax to: 518-252-4050

Email to: JoinPEF@pef.org

Mail to: Membership Information Services
New York State Public Employees Federation
PO Box 12414
Albany, NY 12214-5551

Check every activity in which you might participate:

<input type="checkbox"/> Social Activities	<input type="checkbox"/> Letter Writing
<input type="checkbox"/> Contract Solidarity	<input type="checkbox"/> Division Membership Meetings
<input type="checkbox"/> Demonstrations	<input type="checkbox"/> Welcome Committee
<input type="checkbox"/> Member Mobilizer	<input type="checkbox"/> Other: _____

Additional Information

- Have you received an orientation to PEF?
 No
 Yes – when (date): _____
- Have you served in the U.S. Military? No Yes

Permission to Deduct Union Dues from Paycheck

I hereby authorize the Comptroller of the State of New York or the fiscal or payroll officer of my employer to deduct New York State Public Employees Federation, AFL-CIO (“PEF”) dues from my wages in the amount certified by PEF in this and succeeding years of my employment and membership and to transmit the sums deducted to PEF. I further authorize the Comptroller of the State of New York or the fiscal or payroll officer of my employer to deduct insurance premiums from my wages in the amount necessary to cover my insurance plans or policies sponsored by PEF in this and succeeding years of my employment and to transmit the sums deducted to PEF.

Contributions or gifts to PEF are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses.

Date _____ SIGNATURE of Employee _____

Please return white copy to PEF. Keep pink copy for your records.

PM 1/16

New Employee Guide

Information for CSEA Members Only



CSEA Membership Application

Download: [CSEA Membership Application](#)

What is this form for? To become a CSEA member and receive CSEA membership benefits. CSEA membership will transfer with transferred employees who are already CSEA members.

Is this form mandatory? No. If you are a CSEA-represented employee, union dues will automatically be deducted from your paychecks. You are not required to join the union, however, you cannot enroll in CSEA benefits if you do not join the union.

How do I fill out the form? Employees must:

- Print and complete the form.
- This form requires your signature.

Where do I submit this form? Fax or mail the signed form to:

CSEA
PO Box 7125
Capitol Station
Albany, NY 12224-9901
Fax: 518-465-2382

CSEA Employee Benefits Fund, including Vision, Dental, Disability, Life

The CSEA Employee Benefits Fund provides CSEA-represented employees and their families with:

- Vision Coverage: 28-day waiting period
- Dental Coverage: 28-day waiting period
- Disability and Term Life Insurance

How to Enroll: Go to the [CSEA Employee Benefits Fund](#) website for more information.

Sample View: CSEA Membership Application



APPLICATION FOR CSEA MEMBERSHIP
CSEA, Local 1000 AFSCME, AFL-CIO
143 Washington Avenue, Albany, New York 12210



I HEREBY AUTHORIZE THE CIVIL SERVICE EMPLOYEES ASSOCIATION, INC. (CSEA), LOCAL 1000 AFSCME, AFL-CIO, TO BE MY EXCLUSIVE REPRESENTATIVE FOR COLLECTIVE BARGAINING AND THEREFORE REVOKE ANY OTHER REPRESENTATIVE THAT I MAY HAVE PREVIOUSLY DESIGNATED. I ALSO HEREBY AUTHORIZE THE FISCAL OR PAYROLL OFFICER OF MY EMPLOYER TO DEDUCT CSEA DUES FROM MY SALARY IN THE AMOUNT CERTIFIED BY CSEA IN THIS AND SUCCEEDING YEARS OF MY EMPLOYMENT AND MEMBERSHIP.

DUES, CONTRIBUTIONS OR GIFTS TO CSEA ARE NOT TAX DEDUCTIBLE AS CHARITABLE CONTRIBUTIONS. HOWEVER, THEY MAY BE DEDUCTIBLE AS ORDINARY AND NECESSARY BUSINESS EXPENSES.

Signature: _____ Date: _____

This application may be faxed to the CSEA Membership Dept. at: (518) 465-2382

PLEASE PRINT CLEARLY

<p>Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/></p> <p>FIRST NAME _____ MI _____ LAST NAME _____</p> <p>NICKNAME _____</p> <p>MAILING ADDRESS STREET ADDRESS LINE 1 _____ STREET ADDRESS LINE 2 _____ CITY _____ STATE _____ ZIP _____</p> <p>HOME PHONE (____) _____ AREA CODE _____ <input type="checkbox"/> LISTED <input type="checkbox"/> UNLISTED</p> <p>CELL PHONE (____) _____</p> <p>DATE OF BIRTH ____/____/____ mm dd yyyy</p> <p>HOME E-MAIL _____</p> <p><input type="checkbox"/> CHECK BOX IF YOU ARE A VETERAN</p>	<p>SOCIAL SECURITY NUMBER _____</p> <p>EMPLOYER _____ PLACE OF EMPLOYMENT/LOCATION _____</p> <p>WORK ADDRESS STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____</p> <p>WORK PHONE (____) _____</p> <p>JOB TITLE _____</p> <p>ANNUAL SALARY _____</p> <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 10px;"></div> <p style="text-align: center; font-size: small;">CSEA OFFICE USE ONLY</p>
--	---

• Please fold and tape to seal and drop in any mailbox •

 REV. 2013

New Employee Guide

Information for M/C Only



M/C Vision Plan Information

About: Vision insurance is paid for by the state or negotiating unit and is free for active employees and their families. Vision insurance provided by Davis Vision with a 56-day waiting period

How to Enroll: Use the [PS-404 Health Insurance Transaction form](#)

Learn More:

- [New York State Vision Plan for Employees Designated M/C](#)
- Davis Vision: 1-888-588-4823

M/C Dental Plan Information

About: Dental coverage is paid for by the state or negotiating unit and is free for active employees and their families. Dental coverage provided by Emblem Health with a 6-month waiting period. M/C dental coverage begins the first of the month following 6 full calendar months of continuous employment.

How to Enroll: Use the [PS-404 Health Insurance Transaction form](#)

Learn More:

- [M/C Dental Plan](#)
- [M/C Dental Care Claim Form](#)
- Emblem Health: 1-800-947-0101

GOER M/C Information

Additional information for M/C-designated employees is available on the GOER website at: http://goer.ny.gov/Labor_Relations/ManagementConfidential/index.cfm

M/C Income Protection Plan (IPP) Information

About: The [M/C Income Protection Plan](#) is offered to eligible M/C employees. The plan is administered by the Department of Civil Service. Insurance benefits are provided by Metropolitan Life Insurance Company.

- The IPP is designed to provide income protection in the event you become unable to work due to illness or injury. In combination with other benefit income such as retirement and Social Security benefits, the IPP provides partial continuation of your income during disability to ease financial burdens and help minimize changes in lifestyle. The IPP consists of Short Term Disability Insurance (STD) and Long Term Disability Insurance (LTD).
- If you do not have prior creditable service and you are appointed to an eligible M/C position on or after January 1, 1986, you are automatically covered by the IPP. It is a condition of employment.
- If you have prior creditable service, and you are appointed to an eligible M/C position on or after January 1, 1986, you have 30 days from the effective date of appointment to elect coverage under the IPP. If you do not make a timely election, you cannot participate in the IPP. This will be your only opportunity to elect coverage under the IPP, and your decision to participate or not participate is not reversible.
- If you enrolled in the IPP prior to January 1, 1986, refer to the [Department of Civil Service's information](#) regarding the effective dates of your coverage.

Is this mandatory? Yes. If you do not enroll, the BSC will automatically enroll for you.

How to Enroll: The IPP enrollment form must be completed and returned to BSC Benefits.

- [Income Protection Plan Enrollment Form](#)
- Unclassified positions must also submit the [Income Protection Enrollment Form Addendum](#) with the enrollment form

Learn More: [M/C Income Protection Plan website](#)

New Employee Guide

Information for M/C Only



M/C Life Insurance Information

About: M/C Life Insurance is available through MetLife. Coverage is available for M/C employees, spouse and children. There is a 5 pay period open-enrollment period for new M/C employees. The rates for M/C Life vary depending on the amount of coverage and the age of the employee.

How to Enroll: M/C employees must complete and sign the following forms thoroughly and legibly. Civil Service will not accept forms that have cross-outs or white-outs:

1. [The M/C Life Insurance Enrollment Form \(PS-934\)](#) indicating whether they are enrolling in or declining M/C life insurance. The M/C Life Insurance enrollment deadline is 6 pay periods from an employee's start date. After the 6 pay periods, employees can still enroll but you may need to get a physical and provide a statement of health form. When completing #21 Designation of a Beneficiary on the PS-934:
 - If you are designating a sole beneficiary, complete Sections A & B, only.
 - If you are designating an alternative beneficiary, complete Sections A, C, and attach the Beneficiary Form.
 - Civil Service will not accept forms that have all three sections (21A, B and C) completed.
2. The [MetLife Group Term Life Insurance Beneficiary Designation](#) form to designate their beneficiaries. This form must also be returned to BSC Benefits. When filling out the Beneficiary Form, totals must equal 100% exactly. For example, if 3 beneficiaries are splitting the policy equally, you must allot 33.33%, 33.33% and 33.34%.

Learn More:

- [M/C Life Insurance Website](#)
- [M/C Life Insurance Cost Calculator](#)
- [M/C Life Insurance Bi-Weekly Rates](#)

M/C Voluntary Defined Contribution Plan (VDC)

About: The VDC is a defined contribution retirement program. Benefits are determined by the amount contributed each year and the success of the investments.

- All unrepresented employees hired on or after July 1, 2013, with estimated annual wages of \$75,000 or more are eligible to join the VDC.
- Persons employed on a full-time basis for three months or longer must join a retirement plan within 30 days of their date of appointment. If an employee fails to make a timely election, state law requires placement in ERS. Once an election is made, it cannot be changed during any period of public NYS employment, and is retroactive to the date of enrollment. Permanent/Full-Time employees who are eligible for the VDC but fail to enroll within the first 30 days of employment will be automatically registered in the Retirement System and will no longer be eligible for the VDC.
- Upon completion of 366 days of service, the participant has full & immediate vesting.

The contribution rates to the VDC are as follows:

- Employer Contribution – 8% of salary will be made for the duration of employment.
- Employee Contribution – Required for the duration of employment based upon estimated gross annual wages in a given calendar year, as follows:

Annual Salary	Contribution Rate
\$75,000	4.5%
\$75,000.01 - \$100,000	5.75%
\$100,000 or more	6.0%

VDC employee contributions are made through payroll deduction on a pre-tax basis. All earnings on contributions are tax deferred until they are withdrawn.

How to Enroll: Go to the [Voluntary Defined Contribution website](#) for instructions.

New Employee Guide

Additional Benefits Information for All Employees



Time & Attendance/Employee Emergency Contact Information in LATS

All state employees use the LATS-NY online system to complete timesheets. When you start, your LATS-NY account will not be ready.

We have included a blank timesheet template in this packet. Use this timesheet to manually keep track of your time and attendance while you are waiting for your LATS-NY account to be set up. [Download the timesheet now.](#)

Once your LATS-NY account is activated, you will receive an email from the BSC informing you that your account is ready to use. In this email notification, you will receive your “User Name” and a temporary “Password”, along with the following information:

1. LATS-NY User Handout
 2. Changing Supervisors in LATS-NY
 3. Supervisor Responsibilities in LATS-NY
 4. IPP* (Income Protection Plan) information, if applicable
- *Only applies to MC (Management Confidential) employees

How long does it take to set up a LATS-NY account?

- **New State Employees:** If this is your first job at a New York State agency, your LATS-NY account is usually set up by the end of your first pay period at the new agency.
- **Transfer/Rehire Employees:** If you are transferring from another state agency or being rehired within less than one year of separation from a state agency, your LATS-NY accounts cannot be set up by the BSC until the BSC receives accrual information from your former agency.

Due to the timing of when transactions are submitted to the BSC, transfer employees may not be able to access their timesheets for up to two weeks from their start date. We ask that you track the time you work until you gain access to LATS-NY and can complete your timesheet. To avoid a delay, you can reach out to your former agency to make sure that your accrual information is submitted to the BSC as soon as possible.

Emergency Contact Information in LATS: LATS-NY is the system of record for emergency contact information. New employees should update emergency contact information when logging into LATS-NY for the first time. [Instructions for updating emergency contact information](#) can be found on the BSC website.

An Introduction to Getting Paid by New York State

Information concerning how to understand your paycheck is available on the Office of the State Comptroller website at: http://www.osc.state.ny.us/payroll/files/gettingpaid_2013.pdf

Career Services for Today's State Employees

The NYS Department of Civil Services offers career services for State Employees on the following: career counseling, job options, assessing your skills, preparing a resume, transfer information, how to apply for exams, eligible lists and canvass letters, information on probation and titles you can transfer into and much more.

For information regarding Career Mobility, the Merit System and Examinations, you can visit the Civil Service web site at: www.cs.ny.gov or by contacting the following:

- Career Mobility Office: Empire State Plaza, Building 1, Albany, NY 12239 (518) 485-6199 or toll-free 1-800-553-1322. Fax: (518) 457-9430 Email: cs.sm.careermobility@cs.ny.gov Website: <http://careermobilityoffice.cs.ny.gov/cmo/>
- Examination Information Desk: Empire State Plaza, Building 1, Albany, NY 12239 (518) 457-6216, or toll-free 1-877-697-5627. Fax: (518) 473-2372 Email: examinfo@cs.state.ny.us
- Community Outreach Office, New York, NY: Adam Clayton Powell, Jr. Office Building, New York (212) 961-4326.
- Community Outreach Office, Manhattan, NY: Harlem State Office Building, Manhattan (212) 961-4326.

Deferred Compensation

Deferred Compensation is an optional 457 (b) retirement plan. Employees who choose to enroll may select an amount to be deducted from their paychecks (pre-tax) and invested into the investment options of their choice. For more information and to enroll, go to: www.nysdcp.com

Employee Assistance Program

- EAP is a peer assistance program jointly sponsored by labor and management.
- EAP provides confidential information, assessment, and referral services to NYS employees, their family members, and retirees.
- In order to use EAP, you must first identify and contact your agency/facility's EAP Coordinator using the Coordinator List. Your Coordinator will assist you in determining the nature of your problem and linking you with an appropriate

New Employee Guide

Additional Benefits Information for All Employees

EMPLOYEE BENEFIT

referral. In addition, you may opt to use a Coordinator from an agency other than your own.

- Additional information can be accessed online at <http://www.worklife.ny.gov/eap/index.html> or by calling 1-800-822-0244.

Flex Spending Program

If you are a new employee, you can enroll in Health Care or Dependent Care by submitting a change in status (CIS) application within 60 days of starting your employment. You may also enroll during the open enrollment period (typically in November of each year). More information available at: www.flexspend.ny.gov

- **Health Care Spending Account** – contribute pre-tax dollars to be used to pay for eligible health-related expenses including medical, hospital, prescription drugs, dental, vision and hearing expenses that are not reimbursed by insurance.
- **Dependent Care Advantage Account** – contribute pre-tax dollars to pay for child care, elder care or disabled dependent care. Additional information can be accessed online at <http://www.worklife.ny.gov/eap/index.html> or by calling 1-800-822-0244.

Governor's Office of Employee Relations (GOER)

- [GOER Employee Resources Website](#)
- ["It's Great to Work for New York State" - An Orientation to Employment](#)

New York's 529 Direct Plan College Savings Program

New York's 529 Direct Plan College Savings Program is an investment account that allows employees to set aside pre-tax dollars for higher education expenses. More information available at: www.nysaves.org

New York State Health Insurance Program (NYSHIP) Information Resources

- [NYSHIP online](#)
- [Guide to Navigating NYSHIP online](#)
- [NYSHIP Health Insurance Choices for 2017](#)
- [NYSHIP 2017 Rates & Deadlines](#)

New York State Retirement System

- [New York State Retirement System Website for Tier 6 Members](#)
- [Your Retirement Plan Booklet for ERS Tier 6 Members](#)

NYS-Ride

Contribute pre-tax dollars to be used to pay for certain work-related transportation expenses. More information available at: www.nysride.com

Parking

For parking information for your work location ask the representative conducting your orientation, or contact OGS Parking Management at 518-474-8118 or visit their website at: parking.ogs.ny.gov

Public Officers Law

- [Public Officers Law manual](#)

State Employees Federated Appeal (SEFA)

SEFA offers a way for State contributors to support a network of vital community services all year long through one annual fund raising effort, which occurs in the Fall. Your gift to the State Employees Federated Appeal (SEFA) helps people cope with the kinds of problems many of us hope we never have to face. Charitable giving is a personal decision. SEFA offers State employees the opportunity to choose where their money goes and offers the convenience of payroll deduction. During the annual campaign you will receive information about SEFA and the participating organizations. Learn more at: <http://www.sefanys.org/>

State Employees Federal Credit Union (SEFCU)

All New York State employees and their immediate family members are eligible for membership in the State Employees Federal Credit Union (SEFCU). SEFCU provides financial services, including savings and checking accounts, a holiday savings club, certificates of deposit (CD) and individual retirement accounts (IRA) at convenient locations throughout the State. For additional information, call (518) 452-8183 or toll-free 1-800-727-3328 or visit the SEFCU web site at www.sefcu.com.

In some areas there may be other credit unions available to you. For additional information ask the representative conducting your orientation.

Workers' Compensation Accident Reporting System (ARS)

In the case of a work-related injury or illness, employees must call ARS to report such injury or illness. ARS can be reached by calling their toll free number at 1-888-800-0029 from 8 a.m. to 5 p.m. Monday through Friday (excluding state holidays). Learn more about the [Accident Reporting System](#) & download the [ARS Bulletin](#).

New Employee Guide

Who to Ask for Help

BSC Benefits Mailing Address

BSC Benefits Administration
 W. Averell Harriman State Office Campus
 1220 Washington Avenue
 Building 5, Floor 4
 Albany, NY 12226-1900

BSC Help Line

518-457-4272

BSC Fax

518-457-1879

BSC HR Service Line

Email

Benefits BSCBenefitsAdmin@ogs.ny.gov

Time & Attendance BSCTimeAdmin@ogs.ny.gov

Payroll BSCPayrollAdmin@ogs.ny.gov

Personnel Administration BSCPersonnelAdmin@ogs.ny.gov

Topic

Contact/Resource

Health Insurance

BSC Benefits

Dental/Vision Insurance (CSEA employees) CSEA: <https://cseaebf.com/>

Dental/Vision Insurance (PEF, M/C Employees)

BSC Benefits

Life Insurance (non-M/C Employees)

Applicable Union Benefit Representative

Benefits in Retirement

BSC Benefits

Medical Leave

BSC Benefits

Name Change

BSC Personnel Administration

Address/Phone Number Change

BSC Personnel Administration

LATS Assistance

BSC Time & Attendance

Accruals (Annual Leave, Personal Leave, Sick Leave, etc.)

BSC Time & Attendance

Paychecks/Paychecks Deductions

BSC Payroll

Direct Deposit

BSC Payroll

Lump Sum Payment

BSC Payroll

Salary

BSC Payroll

Workers' Compensation Accident Reporting

1-888-800-0029

Deferred Compensation

1-800-422-8463, www.nysdcp.com

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