

Documentation Requirements Prior to Employee & Dependent Enrollment
Copies of Proofs MUST be provided for enrollment in Medical, Dental and Vision

Eligible Employees: (Proofs)

- Copy of birth certificate
- Copy of Social Security Card

Eligible Employee's Dependents (Proofs)

Employee's Spouse:

- Copy of birth certificate
- Copy of Social Security Card
- Marital status - photo copy of certificate of marriage which specifies date of marriage. If marriage occurred more than 1 year ago, proof of joint ownership/joint financial obligation is also required.

Employee's Natural, Adopted, or Step-Child: **(Proofs)**

- Copy of birth certificate
- Copy of Social Security Card - to be submitted upon receipt in the case of new born dependents
- Proof of full-time student status required for over age 19 (for dental and vision only)
- Proof of disability, if applicable - completion of form PS-451, Statement of Disability

Employee's Other Children (ie, Grandchild) **(Proofs)**

- Proof of support, if applicable - completion of form PS-457, Statement of Dependence
- proof of dependency - completion of form PS-457, Statement of Dependence
- Copy of birth certificate
- Copy of Social Security Card

Address information must be submitted for each individual requesting coverage.

The Domestic Partner enrollment packet describes the proofs that must be submitted. Packets may be obtained by contacting the Benefits Unit at (518) 457-4272. Below is a chart outlining the required proofs. Questions regarding various forms of proof may be directed to the Benefits Unit at the OGS BSC HR.

Spouse	Domestic Partner	Child under age 19	Child over age 19
1. Copy of Birth Certificate	1. Copy of Birth Certificate	1. Copy of Birth Certificate	1. Copy of Birth Certificate
2. Copy of Social Security Card (Copy of Medicare Card if applicable).	2. Copy of Social Security Card (Copy of Medicare Card if applicable).	2. Copy of Social Security Card	2. Copy of Social Security Card (Copy of Medicare Card if applicable).
3. Copy of Marriage Certificate (if marriage took place more than one year ago-see #4 below).	3. Completed PS425 Domestic Partner application and acceptable proof as defined in the application.	3. For Relationship of 'Other', a completed PS457 Statement of Dependence is required along with acceptable proof as defined in the PS 457.	3. Proof of student's full time student status or Approved Medical Leave of Absence Documentation Granted by the School or Doctor, or: Approved PS 451 Statement of Disability Form – applies to dental and vision only; medical coverage is available to age 26 without student status requirement.
4. For marriages that took place more than one year ago, Proof of current joint ownership/joint financial obligation is required (ie: prior year's tax return) If tax document is not provided. a current bank statement, mortgage statement or homeowners policy may be provided			4. For Relationship of 'Other', a completed PS457 Statement of Dependence is required along with acceptable proof as defined in the PS 457.

Mail or Fax Proofs with COMPLETED PS404 to:

**New York State ~ Office of General Services
 Business Services Center ~ Human Resources
 Building 5 W.A. Harriman Campus 4th Floor Albany, NY 12226
 Phone (518) 457-4272 Fax (518) 457-1879**



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

EMPLOYEE BENEFITS DIVISION
INSTRUCTIONS for PS-404
NYS HEALTH INSURANCE TRANSACTION FORM

Boxes 1 – 9

You must complete boxes 1 – 9 with your personal information.
Note: Use the Marital Status Date to show the date of marriage, separation or divorce when those marital statuses are selected.

Box 10 (A – G)

Complete appropriate sections. You are entitled to make separate choices regarding your medical, dental and vision coverage. You may enroll in or decline any of the three, all of the three, or none of the three different coverage options. Also, you may enroll for family coverage in one benefit and individual coverage in another.

Reminder: Enrollees with a Benefit Fund (CSEA, DC-37, UCS and UUP) receive their dental and vision benefits through that fund. If you are a member of one of these groups, you may not enroll for NYSHIP dental or vision benefits.

NEW ENROLLEES (also complete 10.G for family coverage)

Note: If you choose a NYSHIP HMO, the HMO may require you to complete an additional information form for New York State employees.

10.A	Request Enrollment – Individual	Check box to enroll in individual coverage. Check Medical, Dental and/or Vision boxes for coverage selected.
10.B	Request Enrollment – Family	Check box to enroll in family coverage. Check Medical, Dental and/or Vision boxes for coverage selected.
10.C	Pre-Tax Contribution Program (PTCP) Status	New enrollees must make an election (Pre-Tax or Post-Tax) for the PTCP for medical coverage.
10.D	Elect Opt-out Program Coverage (if eligible)	Check box to enroll in the Opt-out Program. Also complete PS-409, Opt-out Attestation form.
10.E	Decline NYSHIP Coverage	Check box to decline coverage. Be sure to check the appropriate boxes for the coverage type declined.

CANCELLATION OR CHANGE IN COVERAGE

10.F	Voluntarily Cancel Coverage	You are entitled to make separate decisions regarding your medical, dental and vision coverage. You may cancel or change your dental and/or vision coverage(s) at any time during the year. If you are enrolled in pre-tax, you may only cancel coverage during the pre-tax open enrollment period, or with a qualifying event (enter the qualifying event). If you are going on Leave Without Pay, also complete Box 12.
10.G	Change Coverage	Check this box to change from Individual to Family or from Family to Individual coverage. If you are enrolled in pre-tax, you may only change coverage from Family to Individual during the pre-tax open enrollment period, or with a PTCP qualifying event (check the qualifying event and enter the Date of Event). Check Medical, Dental, and/or Vision boxes for coverage being changed.
10.G	Add/Change/Delete Dependents	Check the box to add or delete dependents or to change dependent information. Check Medical, Dental, and/or Vision boxes that apply. Complete all dependent information including date of birth. Additional documentation may be required to add the dependent.



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

EMPLOYEE BENEFITS DIVISION
INSTRUCTIONS for PS-404
NYS HEALTH INSURANCE TRANSACTION FORM

Box 11	ANNUAL OPTION TRANSFER REQUEST(S)	Change NYSHIP Option: Complete during annual Option Transfer Period or with a qualifying event (for example, change of address outside of HMO area.) Change Pre-Tax Status: Existing enrollees can only change pre-tax status during the annual Pre-Tax Open Enrollment Period in November.
Box 12	LEAVE WITHOUT PAY	You must complete this section if you are going on leave without pay and want to cancel coverage when you leave the payroll.
	RETIREMENT	You must complete this section if you are leaving the payroll due to retirement to indicate your decision to continue or defer your health coverage as a retiree. Also complete PS-406.2, Deferred Health Insurance for Retirees (Indefinitely) if you request deferment. Check the box to acknowledge that Dental and/or Vision coverage is available under COBRA, if applicable.

AUTHORIZATION	You must SIGN and DATE this form.
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AGENCY/EBD USE ONLY	This section is for Agency and/or EBD use only and is provided to assist with updating the enrollee's record on NYBEAS.
Action/Reason	Transaction that HBA will enter in NYBEAS.
Date of Event	Event date that resulted in the enrollee requesting a change to benefits. Example: first day worked, first day on leave, date of birth, date of marriage.
Hire Date	Original date of hire or rehire. (Only needed for new enrollment).
Date of 1 st Eligibility	The first day the enrollee is eligible for coverage.
Percentage Working	Enrollee's percentage on payroll.
Sick Leave Information - # Hours	Number of sick leave hours for enrollee at time of retirement.
Sick Leave Information - Hourly Rate of Pay	Enrollee's hourly rate of pay based on annual salary at the time of retirement.
Date Entered on NYBEAS	Date HBA processes the transaction on NYBEAS.
Effective Date	The effective date assigned to the transaction by NYBEAS.

Note: When updating NYBEAS, use **Date** in **Authorization Box** as **Date of Request**.

EXAMPLES OF DOCUMENTATION REQUIRED TO PROCESS YOUR TRANSACTION

Note: ALL employees and dependents must provide copies of his or her birth certificate and Social Security card

Spouse	Domestic Partner	Children
Copy of marriage certificate	Completed PS-425 (Domestic Partner series) and required documentation	Completed PS-457 (Statement of Dependence) and required documentation, if applicable
And for marriages dated more than one year prior, proof of current joint ownership/financial obligation	For changes of coverage, copy of death certificate, PS-425.4 (Domestic Partner) or death certificate	Completed PS-451 (Statement of Disability) and required documentation, if applicable
For changes of coverage, copy of marriage certificate, divorce order or death certificate		

11. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW

Change NYSHIP Option Change to: Empire Plan HMO Code HMO Name _____ Opt-out

Change Pre-Tax Status Change to: Pre-Tax Post-Tax Submit during the Pre-Tax Contribution Selection Period (November 1-30)

12. LEAVE WITHOUT PAY AND RETIREMENT STATUS

LEAVE WITHOUT PAY

I wish to continue coverage while I am on authorized leave. Medical Dental Vision
I understand that I will be billed and must pay for this coverage.

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

RETIREMENT

I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage.

I understand the requirements for continuing medical insurance coverage as a retiree and wish to defer my coverage. (*A completed PS-406.2 must be attached.*)

I understand that I will receive an application for COBRA continuation of Dental and/or Vision coverage automatically.

Personal Privacy Protection Law Notification

The information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 457-9375. For information related to the Health Insurance Program, **contact your Agency Health Benefits Administrator**. If, after calling your Agency Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 4:00 p.m.

AUTHORIZATION

I have read the Pre-Tax Contribution Program materials and the Opt-out Attestation Form (if applicable), and have made my selection on Page 1 of this document. I understand that if my coverage is declined or canceled, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date and may forfeit the right to such coverage after leaving State service (vest, retirement, etc.). I am aware of how to obtain a current *Summary of Benefits and Coverage* for the NYSHIP option I have selected. I understand that my failure to provide required proof(s) within 30 days may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims. **I certify that the information I have supplied is true and correct. I hereby authorize deduction from my salary or retirement allowance of the amount required, if any, for the coverage indicated above.**

Employee Signature (Required): _____ **Date:** _____

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	Date of 1 st Eligibility	Percentage Working	Agency Code	Neg. Unit	Ret. System

Retirement Tier	Registration #	Sick Leave Information		Date Entered on NYBEAS	Effective Date
		# Hours	Hourly Rate of Pay		

HBA Signature (Required): _____ **Date:** _____