



Office of General Services
Business Services Center

Business Services Center (BSC)
Human Resources

Planning for Retirement

June 15, 2018

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Important to Know:

- Retirement Date is employee's first day of retirement, their first day off payroll. (First day home, NEVER last day of work.)

Office of State Comptroller



Office of
General Services

Office of the New York State Comptroller

Employees' Retirement System (ERS)

- Once you become eligible to retire and decide on a retirement date you must file an Application for Service Retirement through ERS.
- The Application for Service Retirement ([RS-6037](#)) will need to be submitted to ERS between 15 and 90 days before your retirement date.
- The application is legal document, you must have your signature notarized. Representatives at ERS Consultation Sites serve as notary publics and can assist you in completing the form. (For a list of consultation site offices, visit: www.osc.state.ny.us/retire.)
- ERS is responsible for pension payments. Your monthly pension payment will be mailed or electronically deposited at the end of every month.
Example: a check mailed or a payment deposited at the end of January is your January payment.



Office of the New York State Comptroller

Employees' Retirement System (ERS)

- To estimate your pension, use the Benefit Projector Calculator found on the Retirement System's website at: www.osc.state.ny.us/retire/members/projecting-your-pension.php
- You can request to have a Benefit Projection mailed to your current mailing address on file with the Retirement System, by contacting:

- **Online** – You can go to their website to view information or to e-mail them by going to: www.osc.state.ny.us/retire
- **By Mail** - Please include your retirement or registration number on any correspondence, and mail to:

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

- **By Phone** (weekdays 7:30 am – 4:15 pm)
1-866-805-0990 Local: **(518) 474-7736**
- **By Fax:** (518) 402-4433



**Office of
General Services**

Department of Civil Service Employee Benefits Division



Office of
General Services

New York State Department of Civil Service

Employee Benefits Division (EBD)

- After retirement, EBD becomes the retiree's benefits liaison.
- Additional information for retirees can be found on Civil Service's website at www.cs.ny.gov/retirees/

- How to Contact the Department of Civil Service:

- **By Mail:**

New York State Department of Civil Service
Employee Benefits Division
Albany, NY 12239

- **By Phone:** (518) 457-5754 (Capital District)
1-800-833-4344 (Outside of the Capital District)
 - **By Fax:** (518) 485-5590



BSC Benefits

BSC Benefits

- Prior to retirement, the BSC Benefits Unit will send you a retirement packet highlighting retirement health insurance information. It contains information regarding sick leave credits to be used towards health insurance premiums, dental, and vision coverage.
- BSC Benefits processes sick leave credits towards health insurance premiums after the employee retires.
- BSC Benefits processes all forms that are related to continuing health insurance benefits as a retiree.

Request a Retirement Packet by contacting BSC Benefits
518-457-4272 or bscbenefitsadmin@ogs.ny.gov



- Sent from BSC Benefits Unit
- Customized for each employee
- Provides all benefits related forms and submission instructions
- Contains helpful links for retirees

Retiree Packet



NEW YORK STATE OF OPPORTUNITY | **Office of General Services Business Services Center**

Retirement Package for CSEA-Represented Employees

Retiree Name _____ **Social Security #** XXX-XX-XXXX **Negotiating Unit** _____ **Retirement Date** _____

☐ Enrolled in Benefits ☐ Not Enrolled in Benefits

Dear,

The Business Services Center (BSC) has been notified that you are retiring. The Benefits Unit is providing you this Electronic Retirement Packet to help you understand your benefits and responsibilities as a retiree. Please review the enclosed information carefully. Fill out any necessary forms and return prior to your retirement date shown above.

New York State employees are required to return all state equipment and/or property to their agency prior to leaving state service, e.g. laptops, phones, state IDs. New York State may withhold payments of lump sums until all state issued property is returned.

Please remember that you do not report to work on the effective date of your retirement. If you select August 31 as your retirement date, your last day of work is August 30.

NYSHIP requires retirees and their dependents to be enrolled in Medicare Parts A and B when first eligible for primary Medicare Coverage due to age or disability. Please review the Medicare & NYSHIP page for more information.

If you officially change your retirement effective date with Employees Retirement System:

- Call 518-457-4272 or email OGS.Business.Services.Center.Benefits.and.Payroll.Units, to ensure that an accurate effective date is on record with the BSC.
- Advise your supervisor of the change.

If you have any questions concerning your benefits or the material provided in this packet, please email ogs.sm.bscbenefitsadmin@ogs.ny.gov or call the BSC, Benefits Unit at (518) 457-4272.

Sincerely,



Robert Ellis, Human Resources Specialist I
Business Services Center, Benefits Unit, Offboarding
ogs.sm.bscbenefitsadmin@ogs.ny.gov
518-457-4272

Retirement Package for CSEA-Represented Employees

RETIREMENT AHEAD

Forms

The following forms **MUST** be signed and dated, and returned to the Business Services Center by email at: OGS.sm.bscbenefitsadmin@ogs.ny.gov; or by fax at: 518-457-1879.

- ☐ [PS-404 New York State Health Insurance Transaction Form](#)
This form **MUST** be completed and returned to the BSC prior to your last day of work.
- ☐ [PS-405 Dual Annuitant Sick Leave Credit Election](#)
This form **MUST** be completed and returned to the BSC prior to your last day of work.
- ☐ [PS-406.2 Enrollment Form for Employees Eligible to Defeat Health Insurance Coverage and Sick Leave Credit Calculation Indefinitely in Retirement](#)
This form should be returned **ONLY** if you plan to defer your health insurance.

The following form **MUST** be notarized and returned to the New York State Employee Retirement System (ERS):

- ☐ [RS-6355 Survivor Benefit Program Form](#) (see pages 3-4 of this document)
Return the notarized form to: NYS Retirement System, 110 State Street, Albany, NY 12242

Sick Leave Credit

The Department of Civil Service: [Sick Leave Calculator](#)

When you retire, you may be able to use the value of your unused sick leave to offset the cost of NYSHIP coverage. If you are retiring with a Disability Retirement, use the [Disability Sick Leave Credit Calculator](#).

To use the calculator, click the link above, then select the option for "I am a New York State Active Employee (NY)" and press "Continue". Next, select your negotiating unit and health insurance plan and press "Continue". From the next page click the "Planning to Retire" link, then click on "Sick Leave Credit Calculator".

Input your Date of Retirement, Pay Rate, Standard Work Schedule, Hours of Unused Sick Leave (See your latest time-card) and Age at Retirement. Be sure to review the results for both Dual Annuitant Sick Leave Credit and Single Annuitant Sick Leave Credit as you must choose between these two options.

All information provided by this calculator is an estimate, based on the information you input. Your actual sick leave will be calculated at the time of your retirement. The amount of your sick leave credit may vary based upon additional time earned or used. You must select either the Single or Dual Annuitant option by completing form PS-405 before your retirement date. You cannot change your annuitant selection after you have retired. If this form is not received prior to your retirement date, your sick leave credit will automatically default to the Single Annuitant Option.

If you have questions about your sick leave credit or annuitant options, please contact the BSC Benefits unit at: ogs.sm.bscbenefitsadmin@ogs.ny.gov or call 518-457-4272.

Information for CSEA Retirees

[Information for Retirement Planning](#)
[Medicare & NYSHIP](#)
[Medicare & You](#)
[Medicare Part B Enrollment Form](#)
[Back to Work for returning retirees](#)
[Planning for Retirement Booklet](#)

[Retiree Choices 2017](#)
[Retiree Rates 2017](#)
[Retirement Planning Video Library](#)
[GOER Web Services YouTube Channel](#)
[General Information Book](#)
[Denial and Vision Fact Sheet](#)
[Office of the State Comptroller's Retiree Resources Page](#)

Survivor's Benefit Program

The Survivor's Benefit Program is a financial protection plan that provides a minimum death benefit to the survivors of New York State retired employees. Your beneficiary may receive a benefit of \$3,000.

Print the Eligibility of Retired Employee for Survivors Benefit (RS 6355), see pages 3-4 of this document, and complete section C and sign before a Notary Public. Return the notarized form to: NYS Retirement System, 110 State Street, Albany, NY 12242.



Office of General Services

Request a Packet
Call 518-457-4272
bscbenefitsadmin@ogs.ny.gov

Survivor's Benefit Program (RS 6355)



Office of the New York State Comptroller
Office of Retirement and Social Security Administration
Employee Retirement System
Pension and Plan Administration System
110 State Street, Albany, New York 12244-0001

SURVIVOR'S BENEFIT PROGRAM Eligibility of Retired Employee for Survivor's Benefit

RS 6355
(Rev. 3/14)

PART A - TO BE COMPLETED BY DEPARTMENT OR AGENCY (See instructions on reverse)

1. Name (Last, First, Middle Initial) _____ (DOB) _____ 2. Social Security Number _____
3. Date of Birth _____ 4. Date of Appt. _____ 5. Agency Code _____ 6. Payroll Item No. _____
7. Name(s) of Retirement System(s) _____ 8. Ret. Reg. No. _____ 9. Title _____
10. Eligibility: (Check box "Y" if all are applicable; leave blank if not applicable; see detailed instructions on reverse)
a. ☐ Employee has ten years of full-time State service within the last 15 years, (minimum salary of at least 1,000 hours times the state minimum wage during each period or regularly scheduled work week of 35 hours or more).
b. ☐ Employee retired from the system covered in number 7 effective _____ phase _____
c. ☐ Employee retired from the State University, or Department of Education optional retirement program after attaining age 65 and began receiving retirement allowance within 180 days of last day of employment.
d. ☐ Employee terminated state service effective _____ (date) _____ after attaining age 65.
e. ☐ Employee last day of effective _____ (date) _____ and retired within one year of last day date.

11. I certify that the information above is as shown in the records at this agency and I believe the same are true and correct. This employee has received Form VO 1085.
Signature _____ Title _____
Agency _____ Address _____ Date _____

PART B - TO BE COMPLETED BY SURVIVOR'S BENEFIT PROGRAM

☐ ELIGIBLE ☐ INELIGIBLE
Signature _____ Date _____

PART C - TO BE COMPLETED BY EMPLOYEE AT TIME OF INITIAL RETIREMENT (DO NOT USE AS A CHANGE OF BENEFICIARY IF PREVIOUSLY RETIRED)

DESIGNATION OF BENEFICIARY - If you are not a member of a retirement system or pension plan supported by State funds or if you are a member but have not designated a beneficiary to such system to receive retirement benefits (hereafter you have chosen Option 1), you should check box 1, and designate a beneficiary letter for the Survivor's Benefit Program. If you are a member of a retirement system and have selected an option under which you have designated a beneficiary (any option other than 1), the survivor's benefit must be paid to the same beneficiary designated by the retirement system. Therefore, box 2 should be checked.
a. ☐ I have selected Option 1 and have, therefore, not designated a beneficiary to a retirement system supported by State funds to receive retirement benefits. I authorize the Comptroller to pay to the beneficiary named below any survivor's benefit due to my benefit. I understand that I can change this designation at any time. (Please check box 2 if not a member of any retirement system.)

(COMPLETE DESIGNATION OF BENEFICIARY(IES) ONLY IF YOU HAVE SELECTED OPTION 1 OR IF YOU DO NOT BELONG TO ANY RETIREMENT SYSTEM)

DESIGNATION OF PRIMARY BENEFICIARY(IES) (Use your assignment to survivor's name, given death, not name, unless death must occur on time.)

Name _____ Title _____
Relationship _____ Birth Date _____ Relationship _____ Birth Date _____
Res. Sys. No. _____ Res. Sys. No. _____
Address (Street, City, State, Zip) _____ Address (Street, City, State, Zip) _____

DESIGNATION OF CONTINGENT BENEFICIARY(IES)

If all the above named beneficiaries are listed (1, 2, 3, 4), and amount payable on my benefit should 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 any benefit equally. This designation revokes all previous designations I have made.

Name _____ Title _____
Relationship _____ Birth Date _____ Relationship _____ Birth Date _____
Res. Sys. No. _____ Res. Sys. No. _____
Address (Street, City, State, Zip) _____ Address (Street, City, State, Zip) _____

To share and share alike unless otherwise specified of those surviving the death benefit payable under the Survivor's Benefit Program as the result of my death after retirement, I reserve the right to change the above designation at any time without any cost. I hereby, about this, should I survive the above mentioned beneficiaries, the amount which otherwise would have been payable to them as transmission on term, shall be paid to my Estate or to such other beneficiary as I shall hereafter designate, by written designation filed with the Comptroller in accordance with the rules and regulations provided. I understand that the above designation of beneficiary(ies) is for my death benefit under the Survivor's Benefit Program only, and does not affect any designation of beneficiary(ies) made in conjunction with my retirement benefits.

b. ☐ I have selected an option other than 1 and understand that the survivor's benefit must be paid to the same beneficiary(ies) designated to the retirement system.

THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC.

Employee's Signature _____ City _____ State _____ Zip Code _____
Street Address _____

ACKNOWLEDGEMENT

To be Completed by a Notary Public

State of _____ County of _____

On this _____ day of _____, before me personally appeared _____ to me known and known to me to be the same person described in and who executed the foregoing instrument, and _____ he duly acknowledged to me that _____ he executed the same.

(Signature of Officer) _____

Notary Stamp Must Be Affixed

PERSONAL PRIVACY PROTECTION LAW

In accordance with the Personal Privacy Law, you are hereby advised that participants 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 also provides certain information to participating employers. The official responsible for maintaining these records is the Director of Unemployment and Employee Services, New York State and Local Retirement System, 110 State Street, Albany, NY 12244-0001 (Telephone Number 518-485-6000 or 1-800-755-7276).

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, 34, 311 and 312 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

- Will be provided to retirees in BSC Retirement Packet (Part A will be pre-filled)
- Must be notarized
- Original must be returned to :

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



Office of
General Services

BSC Time & Attendance



BSC Time & Attendance

- Employees must submit all timesheets including their final timesheet in LATs on their last day in the office prior to retirement. Unsubmitted timesheets will result in a delay of any final lump sum payouts the retiree is eligible to receive.
- If the employee has been approved to use accruals for time off prior to their official retirement date, the employee should complete and submit the timesheet to reflect the use of leave accruals. Supervisors are able to approve timesheets in advance.
- If the effective date of retirement is not the first day of a pay period, BSC Time & Attendance will code the timesheet with the appropriate retirement code upon receipt of a transaction from the employee's agency. Employees can reach out to the BSC Time & Attendance Unit with any questions concerning their timesheet either by e-mail at bsctimeadmin@ogs.ny.gov or by calling (518) 457-4272.

BSC Payroll



BSC Payroll

- The BSC Payroll Unit will process retiree's lump sum payment for:
 - Unused vacation leave (up to 30 days)
 - 5 day salary withholding
 - Non-comp accruals (up to 30 days)
 - VRWS (Voluntary Reduction in Work Schedule) accruals (No Maximum)
 - Over 40 comp CSEA and PEF (up to 120 hours)

- The lump sum payment is typically paid to retirees in a check that is issued 2-3 weeks after the employee receives their final paycheck for time worked/charged, provided that timecards are submitted and approved timely. (6-7 weeks after retirement date).
If you are enrolled in direct deposit for paychecks, lump sum will automatically be direct deposited.

- To make additional Payments to Deferred Compensation, Employees should contact *Deferred Compensation* at www.nysdcp.com or 1-800-422-8463 at least 30 days prior to retirement.

Retiree Health Insurance Eligibility



Eligibility for Health Insurance Benefits in Retirement

- You must be enrolled in NYSHIP as an enrollee or a dependent at the time of your retirement. Enrollment in NYSHIP may be through The Empire Plan, a NYSHIP HMO **or** the Opt-out Program.
- You must satisfy the requirements for retiring as a member of a retirement system that is administered by New York State (ERS).
- You must be 55 years old and have a minimum of 10 years of service in a position eligible for NYSHIP benefits.



Requirements for Disability Retirement

- You must be enrolled in NYSHIP at the time of your retirement.
- If your disability retirement is non-work-related, 10 years of NYSHIP benefits-eligible service is required, and age requirement is waived.
- If your disability retirement is work-related, the age and service requirements are both waived.

Once Eligibility is established, you may:

- Retire with your benefits in place. Benefits as an active employee end effective 28 days after the last day in the pay period in which your retirement is effective. If you continue your health insurance as a retiree, there will be no break in coverage.

OR

- Defer the start of your benefits as a retiree for an indefinite time period.

Health Insurance Transaction Form (PS-404)

 Department of Civil Service	EMPLOYEE BENEFITS DIVISION HEALTH INSURANCE TRANSACTION FORM FOR NYS & PE EMPLOYEES		PS-404 (9/17)

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

EMPLOYEE INFORMATION (All employees must complete)			
1. Last Name	First Name	MI	2. Social Security Number
3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			
4. Permanent Address Street	City	State	Zip
5. Mailing Address (if different) Street	City	State	Zip
6. Work Location & Address Street	City	State	Zip
7. Date of Birth	8. Telephone Numbers Primary _____ Work _____		
9. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Marital Status Date		
10. 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			

11. ELECT OR DECLINE COVERAGE	
A. Choose a Pre-Tax election (Only eligible for Pre-Tax deductions if newly eligible or if requested during the PTPC election period, Nov 1-30)	
1. <input type="checkbox"/> Elect Pre-Tax Status for Premium deduction	2. <input type="checkbox"/> Elect After-Tax Status for Premium deduction
B. Select a NYSHIP Coverage Option (Choose option 1, 2, 3 or 4)	
1. Individual Enrollment	Medical (19) (Select Empire Plan or HMO) <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code _____ Name _____ <input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14)
2. Family Enrollment (Complete box 13 on page 2)	Medical (19) (Select Empire Plan or HMO) <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code _____ Name _____ <input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14)
3. Opt-out Program (NYS Medical only)	<input type="checkbox"/> Individual Opt-out <input type="checkbox"/> Family Opt-out (Complete Box 13) <input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14) If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.
4. Decline Coverage	<input type="checkbox"/> Medical (19) <input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14)

12. CHANGE OR CANCEL EXISTING COVERAGE	
A. Change Coverage: <input type="checkbox"/> Medical (19) <input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14) Date of Event: _____	
<input type="checkbox"/> Change to FAMILY (Complete box 13) <input type="checkbox"/> Change to INDIVIDUAL	
<input type="checkbox"/> Marriage <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Newborn <input type="checkbox"/> Request coverage for dependents not previously covered <input type="checkbox"/> Previous coverage terminated (proof required) <input type="checkbox"/> Dependent returned to full-time student status (Dental and Vision only) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Divorce <input type="checkbox"/> Termination of Domestic Partnership (Attach completed PS-425.4) <input type="checkbox"/> Only dependent ineligible due to age <input type="checkbox"/> I voluntarily cannot coverage for my dependents <input type="checkbox"/> Only dependent died <input type="checkbox"/> Only dependent married (Dental and Vision only) <input type="checkbox"/> Only dependent graduated (Dental and Vision only) <input type="checkbox"/> Other: _____
NOTE: If you are indicating a change in marital status to Divorced or Separated, please be sure to update the address information for the dependent in Box 13 if applicable.	
B. Voluntarily Cancel Coverage: <input type="checkbox"/> Medical (19) <input type="checkbox"/> Dental (11) <input type="checkbox"/> Vision (14) Qualifying Event: _____	
NOTE: If you are enrolled in the Pre-Tax Contribution Program, you may make changes during the Annual Option Transfer Period or when experiencing a qualifying event.	

NYS Department of Civil Service
Albany, NY 12239

Health Insurance Transaction Form
Page 2 - PS-404 (9/17)

13. 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)
A	M						
D	D						
C	V						
A	M						
D	D						
C	V						
A	M						
D	D						
C	V						
A	M						
D	D						
C	V						

14. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW	
Change NYSHIP Option	Change to: <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code _____ HMO Name: _____
Elect Opt-out (NYS Medical only)	<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.
Change Pre-Tax Status	Change to: <input type="checkbox"/> Pre-Tax <input type="checkbox"/> After-Tax Submit during the Pre-Tax Contribution Selection Period (November 1-30)

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 Privacy Protection Law, call (518) 473-2624. For information related to the Health Insurance Program, contact your Health Benefits Administrator. If, after calling your Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-633-3444 between the hours of 9:00 a.m. and 4:00 p.m. Eastern time.	
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 USE ONLY				
Retirement Tier	Registration #	Sick Leave Information # Hours Hourly Rate of Pay	Date Entered on NYBEAS	Effective Date
HBA Signature (Required): _____			Date: _____	

Provided in Retirement packet from BSC Benefits unit.

Return signed, completed form to BSC Benefits:

Fax: 518-457-1879

bscbenefitsadmin@ogs.ny.gov



Office of General Services

Sick Leave Credit



Sick Leave Credit

- Your unused sick leave, up to 200 days (1,500 hours for 37.5 hour/week employees) will reduce the monthly cost of your health insurance in retirement.
- At the time of your retirement, you may choose the *Single Annuitant* option and receive 100% of your sick leave credit to offset the cost of your health insurance or select the *Dual Annuitant* option and receive 70% of your sick leave credit.
- The cost of your health insurance will change during the course of your retirement; however, once a selection is made your sick leave credit will remain the same throughout your lifetime.

Note: Sick Leave Credit is used to add time to your retirement service up to 200 days. The Sick Leave Credit cannot be used to reach a milestone. For Example: An employee with only 24 years and 9 months cannot use the Sick Leave Credit to reach a 25 year milestone.



How to Estimate Your Sick Leave Credit

$$\begin{array}{lcl} \text{Hours of} & & \text{Hourly Rate of Pay} \\ \text{Unused Sick} & \times & \text{(Annual salary plus additional} \\ \text{Leave} & & \text{constant salary factors;} \\ & & \text{location pay, shift or geographic} \\ & & \text{differential, inconvenience pay)} \\ & = & \text{Total Dollar} \\ & & \text{Value of Sick} \\ & & \text{Leave} \end{array}$$

$$\begin{array}{lcl} \text{Total Dollar} & & \text{Life Expectancy in} \\ \text{Value of} & \div & \text{Months} \\ \text{Sick Leave} & & \\ & = & \text{Your Monthly} \\ & & \text{Sick Leave} \\ & & \text{Credit} \end{array}$$

For more information or to access the Sick Leave Calculator:

www.cs.ny.gov/employee-benefits



Office of
General Services

Dual Annuitant - Sick Leave Credit Option

- Allows your covered dependent survivor(s) to continue to use your sick leave credit to offset their cost of health insurance if you predecease them.

Your Sick Leave Credit is reduced to 70% of its value.

- If you do not elect this option, it does **NOT** affect your dependent survivor's eligibility to continue NYSHIP coverage. It **ONLY** impacts your dependent's ability to use your sick leave credit.

Dual Annuitant - Sick Leave Credit Option (Continued)

- You do not need to be enrolled in family coverage at the time of retirement to choose Dual Annuitant Sick Leave Credit Option.
- You must submit a completed, signed election form (PS-405) **BEFORE** you leave the payroll.
- This is a **ONE-TIME** irrevocable decision.
- If form PS-405 is not returned to the BSC **prior** to retirement, 100% of your sick leave credit will be applied to your premium (Single Annuitant Option).



Dual Annuitant Sick Leave Credit Election (Continued)

 New York State Department of Civil Service Alfred E. Smith State Office Building Albany, NY 12239	EMPLOYEE BENEFITS DIVISION Dual Annuitant Sick Leave Credit Election PS-405 (5/09)
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When you retire, you may apply for either: (a) the Single- Annuitant or; (b) Dual Annuitant Option, where 70 percent of your calculated monthly sick leave credit is applied towards your monthly health insurance premium in retirement.

If you elect the "Single- Annuitant" Option - 100 % of your sick leave credit will be used to offset your monthly health insurance premium for as long as you are enrolled, until you die. Your sick leave credit will terminate upon your death.

If you elect the "Dual- Annuitant" Option - 70 % of the reduced sick leave credit will be applied towards your monthly health insurance premiums for as long as you are enrolled. Upon your death, the same 70% of your sick leave credit will be applied towards the monthly health insurance premiums for your enrolled dependent(s), until they lose eligibility. Only dependents enrolled under your coverage at the time of your death may receive this benefit.

Check One:

a. <input type="checkbox"/> Single- Annuitant Option	Please apply 100 % of my monthly sick leave credit towards my monthly health insurance premium. I understand that if I select this option, my sick leave credit will end with my death and will not be available to my covered dependent(s).
b. <input type="checkbox"/> Dual – Annuitant Option	Please apply 70 % of my monthly sick leave credit towards my monthly health insurance premium. I understand that if I select this option, my sick leave credit will be used to reduce my health insurance premiums during my lifetime, and also to reduce the premium of my covered dependent(s) for the duration of their eligibility if I predecease them. If my dependents die before me, I will retain the 70 percent sick leave credit.

**YOU MUST MAKE THIS ONE-TIME CHOICE PRIOR TO RETIREMENT
NO LATER THAN YOUR LAST DAY WORKED.**

If you do not make a choice, the "Single- Annuitant Option" - Full Sick Leave Credit (100%) will be applied automatically to your premium. This Full Sick Leave Credit will end when you die and it will not be available to covered surviving dependent(s).

I have read the information provided to me regarding Dual Annuitant Sick Leave Credit and have made my selection. I understand that I may not change my selection after I retire.	
Signature: Please Print Name and Address:	Date: Health Insurance ID Number:
Signature of Agency Health Benefits Administrator:	Date:
Agency Name:	Agency Code:

Note: The State Service Sick Leave Credit Preservation Form (PS-410) verifies State Service Dates and Sick Leave Credit. If your covered spouse is a New York State employee and eligible for health insurance coverage, your spouse should obtain a completed PS-410 from the Health Benefits Administrator upon his or her retirement. This completed form is necessary if your spouse wishes to obtain health insurance in his/her own name at a later date.

Personal Privacy Protection Law Notification:

This information you provide on this application is requested for the principal purpose of enabling the Department of Civil Service to process your election concerning the use of sick leave credit to reduce health insurance premiums after retirement. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subsections (b), (e) and (f). Failure to provide the information requested may interfere with our ability to maintain such record. 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 Privacy Protection Law, call (518) 457-9375. If you have a question, regarding this form or the health insurance coverage, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

Please make a copy of this signed election for your records.

Provided in Retirement packet from BSC Benefits unit.

Request a Packet : call 518-457-4272
bscbenefitsadmin@ogs.ny.gov

Return signed, completed form to BSC Benefits:

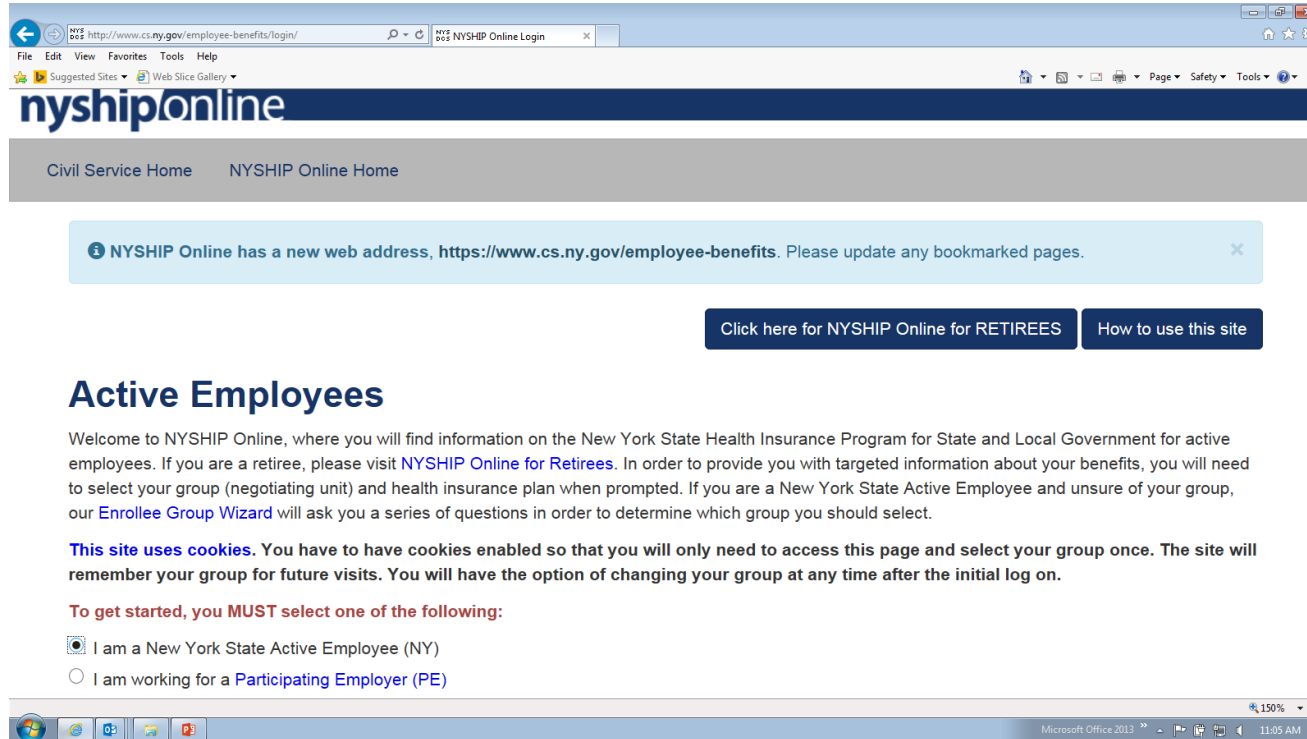
Fax: 518-457-1879
bscbenefitsadmin@ogs.ny.gov



**Office of
General Services**

Retirement Information on Civil Service's Website

www.cs.ny.gov/employee-benefits



The screenshot shows a web browser window with the address bar displaying <http://www.cs.ny.gov/employee-benefits/login/>. The page features the "nyshiponline" logo and navigation links for "Civil Service Home" and "NYSHIP Online Home". A blue banner at the top of the page content area contains the text: "NYSHIP Online has a new web address, <https://www.cs.ny.gov/employee-benefits>. Please update any bookmarked pages." Below this banner are two buttons: "Click here for NYSHIP Online for RETIREES" and "How to use this site". The main heading is "Active Employees". The text below the heading reads: "Welcome to NYSHIP Online, where you will find information on the New York State Health Insurance Program for State and Local Government for active employees. If you are a retiree, please visit [NYSHIP Online for Retirees](#). In order to provide you with targeted information about your benefits, you will need to select your group (negotiating unit) and health insurance plan when prompted. If you are a New York State Active Employee and unsure of your group, our [Enrollee Group Wizard](#) will ask you a series of questions in order to determine which group you should select." A note states: "This site uses cookies. You have to have cookies enabled so that you will only need to access this page and select your group once. The site will remember your group for future visits. You will have the option of changing your group at any time after the initial log on." Below this, a red instruction says: "To get started, you MUST select one of the following:". Two radio buttons are provided: "I am a New York State Active Employee (NY)" (which is selected) and "I am working for a Participating Employer (PE)". The browser's taskbar at the bottom shows the date and time as 11:05 AM.

NYSHIP Online has a new web address, <https://www.cs.ny.gov/employee-benefits>. Please update any bookmarked pages.

[Click here for NYSHIP Online for RETIREES](#) [How to use this site](#)

Active Employees

Welcome to NYSHIP Online, where you will find information on the New York State Health Insurance Program for State and Local Government for active employees. If you are a retiree, please visit [NYSHIP Online for Retirees](#). In order to provide you with targeted information about your benefits, you will need to select your group (negotiating unit) and health insurance plan when prompted. If you are a New York State Active Employee and unsure of your group, our [Enrollee Group Wizard](#) will ask you a series of questions in order to determine which group you should select.

This site uses cookies. You have to have cookies enabled so that you will only need to access this page and select your group once. The site will remember your group for future visits. You will have the option of changing your group at any time after the initial log on.

To get started, you MUST select one of the following:

☒ I am a New York State Active Employee (NY)

☐ I am working for a [Participating Employer \(PE\)](#)

Retirement Information on Civil Service's Website

- Select Negotiating Unit
- Select Empire Plan / HMO

The screenshot shows a web browser window with the address bar displaying <http://www.cs.ny.gov/employee-benefits/login/>. The browser's menu bar includes File, Edit, View, Favorites, Tools, and Help. A notification banner at the top states: "NYSHIP Online has a new web address, <https://www.cs.ny.gov/employee-benefits>. Please update any bookmarked pages." Below this, the heading "New York State Active Employees" is followed by the instruction: "Select your group (negotiating unit) from the drop-down menu AND select your health insurance plan to access targeted information about your benefits." A red prompt reads: "You MUST Choose Your Group Now:". Below this is a dropdown menu with the text "Select" and a downward arrow. The word "AND" is displayed in bold. Another red prompt reads: "You MUST Choose Your Plan to continue:". Below this are three radio button options: "Empire Plan Enrollee", "HMO Enrollee", and "Dental and/or Vision Only Enrollee". A blue "Finish" button is located at the bottom left. A large grey arrow points upwards on the right side of the form. The Windows taskbar at the bottom shows icons for Internet Explorer, Microsoft Office Word, and other applications, with the system clock indicating 11:05 AM on 6/15/2018.

NYSHIP Online has a new web address, <https://www.cs.ny.gov/employee-benefits>. Please update any bookmarked pages.

New York State Active Employees

Select your group (negotiating unit) from the drop-down menu AND select your health insurance plan to access targeted information about your benefits.

You MUST Choose Your Group Now:

Select

AND

You MUST Choose Your Plan to continue:

☐ Empire Plan Enrollee

☐ HMO Enrollee

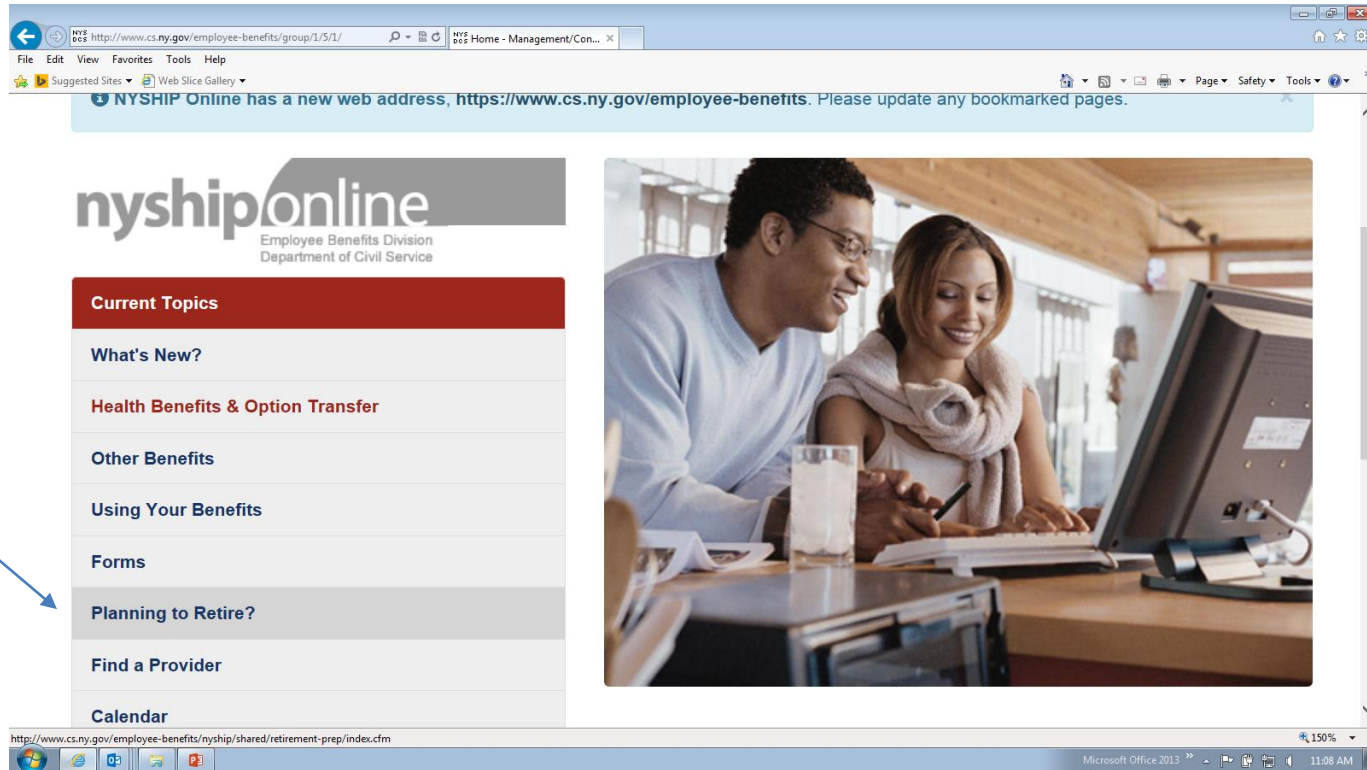
☐ Dental and/or Vision Only Enrollee

Finish



Office of
General Services

Retirement Information on Civil Service's Website (continued)



The screenshot shows a web browser window displaying the NYSHIP Online website. The address bar shows the URL <http://www.cs.ny.gov/employee-benefits/group/1.5/1/>. A notification banner at the top states: "NYSHIP Online has a new web address, <https://www.cs.ny.gov/employee-benefits>. Please update any bookmarked pages." The website header features the "nyshiponline" logo and the text "Employee Benefits Division, Department of Civil Service". A left-hand navigation menu lists several topics: "Current Topics", "What's New?", "Health Benefits & Option Transfer", "Other Benefits", "Using Your Benefits", "Forms", "Planning to Retire?", "Find a Provider", and "Calendar". A blue arrow points to the "Planning to Retire?" link. To the right of the menu is a photograph of a man and a woman smiling while looking at a computer monitor. The browser's status bar at the bottom shows the page title "http://www.cs.ny.gov/employee-benefits/nyship/shared/retirement-prep/index.cfm", the date and time "11:08 AM", and the text "Microsoft Office 2013".

Retirement Information on Civil Service's Website (continued)

Pre-Retirement Presentation:

The New York State Health Insurance Program (NYSHIP) Pre-Retirement presentation was developed to assist New York State Executive Branch employees with guidance as they begin to plan their retirement. Please contact your Health Benefits Administrator (HBA) for seminar information. Click [here](#) to access the pre-retirement seminar event calendar.



Additional Information:

Retiree Option Transfer Policy – NYSHIP enrollees with retiree benefits are permitted to change health insurance options at any time once during a 12-month period. This policy allows retirees more flexibility and time to consider personal factors affecting their health insurance option. Click [here](#) for FAQs and more information.

Dental and Vision Plans – Dental and vision benefits you may currently be receiving as an employee are not part of your health insurance and do not continue automatically. If you want to continue dental and vision benefits after retirement, you must request enrollment and pay a monthly premium. Click [here](#) for more information.

Sick Leave Calculator – When you retire, you may be able use the value of your unused sick leave to reduce the cost of New York State Health Insurance Program (NYSHIP) coverage. Click [here](#) to estimate the value of your sick leave credit. Please confirm your eligibility with your Health Benefits Administrator (HBA).

NYSHIP Publications:

The information provided in these publications relates to retirement planning.



[Planning for Retirement](#)

ship/shared/.../2018 February 2018 presentation.pdf



[Planning for Retirement Benefit Checklist](#)



[Welcome to the Employee Benefits Division](#)



[On the Road with The Empire Plan](#)

Retirement Information on Civil Service's Website (continued)

Sick Leave Credit Calculator

When you retire, you may be able use the value of your unused sick leave to offset the cost of NYSHIP coverage. Check with your Health Benefits Administrator (HBA) to confirm eligibility. To estimate your monthly sick leave credit, enter the information below. If you are retiring with a Disability Retirement, use the [Disability Sick Leave Credit Calculator](#).

Effective Date of Retirement

On or After April 1, 2012

Pay Rate \$

0

Standard Work Schedule

8 Hours Per Day or 40 Hours Per Week

Hours of Unused Sick Leave

0

Age at Retirement

50

Dual Annuitant Sick Leave Credit

No

Calculate

Reset

How Your Sick Leave Is Calculated

Hourly Rate of Pay

X

Hours of Unused Sick
Leave

=

Total Value of Sick Leave

Total Value of Sick Leave

÷

Life Expectancy in
Months

=

Your Estimated Monthly
Sick Leave Credit *

* This is an estimate based on the information provided. For the most accurate calculation of your sick leave credit see your Health Benefits Administrator.



Office of
General Services

Deferring Health Insurance


Deferred Health Insurance at Retirement

- If you choose to defer your health insurance, the value of your Sick Leave Credit may increase when you reinstate your benefits.

To Defer:

- You **MUST** be enrolled in NYSHIP and establish eligibility for retiree coverage.
- You **MUST** prove enrollment in other coverage.
- You **MUST** elect to defer before you leave the payroll.

Deferring Health Insurance Coverage in Retirement

 <p>State of New York Department of Civil Service Alfred E. Smith State Office Bldg. Albany, NY 12239</p>	<p>EMPLOYEE BENEFITS DIVISION Enrollment Form For Employees Eligible To Defer Health Insurance Coverage And Sick Leave Credit Calculation Indefinitely In Retirement PS-406.2 (8/06)</p>
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Information For Employees Eligible To Defer Health Insurance Coverage And Sick Leave Credit Calculation Indefinitely In Retirement

- Enrollees who have health insurance coverage through their post-retirement employment, or through their spouse's employer, are eligible to defer indefinitely the activation of their New York State Health Insurance Program (NYSHIP) coverage as retirees.
- Retirees use their sick leave credit to reduce their health insurance premiums. If you defer your NYSHIP coverage when you notify EBD to activate your coverage, your sick leave credit will be calculated when you are older and will have a greater dollar value than if it were calculated immediately at retirement. You will not have to pay NYSHIP premiums while your coverage is deferred.
- If you die while your coverage is deferred, your spouse and/or eligible dependents may transfer back to NYSHIP. Coverage for the eligible survivors would begin on the day following your death. Eligible survivor(s) who wish to enroll should do so as soon as possible to avoid retroactive premium payments.
- If you wish to defer your retiree health insurance coverage, furnish proof to your agency health benefits administrator that you have coverage through post-retirement employment, or through your spouse's health care plan, and complete the form below. Keep a copy of the completed form for your records.

ENROLLMENT FORM FOR EMPLOYEES ELIGIBLE TO DEFER HEALTH INSURANCE COVERAGE AND SICK LEAVE CREDIT CALCULATION INDEFINITELY IN RETIREMENT

*I have read the information provided to me regarding Deferred Health Insurance Coverage for Retirees.
I wish to defer my New York State Health Insurance Program Coverage, understanding that I may defer only once.*

My last day on the payroll is: Month: _____ Day: _____ Year: _____

I understand that if I pre-decease my spouse and/or other eligible dependent(s) while coverage is deferred, they may transfer back to the New York State Health Insurance Program. My eligible survivor(s) should send a written request for enrollment to the Employee Benefits Division Operations-Deferred Health Insurance Coverage Unit, at the above address within 90 days of my death.

I understand that I may reactivate my enrollment in the New York State Health Insurance Program at any time, by writing to the Employee Benefits Division Operations-Deferred Health Insurance Coverage Unit, at the above address.

- Check One: ☐ Proof of my continued coverage in my spouse's health care plan is attached.
☐ Proof of my coverage through post-retirement employment is attached.

→ Signature: _____		Date: _____
Please Print Name in this Space: _____		Social Security Number: _____
→ Signature of Agency Health Benefits Administrator: _____		Date: _____
Agency Name: _____		Agency Code: _____
<p>Personal Privacy Protection Law Notification: This information you provide on this application is requested for the principal purpose of deferring activation of your health insurance coverage. This information will be used in accordance with Public Officers Law Section 96 (1) also known as the Personal Privacy Protection Law. Failure to provide the information requested may prevent the Department from processing this application. This information will be maintained by the Director of the Employee Benefits Division, NYSD Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 457-6375. If you have a question, regarding this form or the health insurance coverage, please call (518) 457-6754 or 1-800-633-4344 between the hours of 9:00 a.m. and 3:00 p.m.</p>		

Please make a copy of this signed election form for your records.

Provided in Retirement packet from BSC Benefits unit.

Complete **ONLY** if you want to defer your health insurance at the start of retirement.

Return signed, completed form to BSC Benefits:

Fax: 518-457-1879

bscbenefitsadmin@ogs.ny.gov



**Office of
General Services**

Cost / Payment Information



Payments for Retiree Health Insurance

➤ ERS – Pension Check Deduction

- Pension check deductions may take several months to begin.
- You may be billed by the Department of Civil Service and must pay until deductions begin. Failure to pay premium bills could result in cancellation of coverage.

➤ Direct-pay billings

- Employees pay premiums directly. Failure to pay premium bills could result in cancellation of coverage.

Dependent Survivors



What if I predecease my dependents?

- 3-month extended benefits period for all covered dependents.
- Coverage usually continues under the same ID during the 3-month extension
- (HMO enrollees should check with their HMO).
- Coverage during the 3-month extension is provided at no cost to the dependent(s).

Coverage After the 3-month Extension

- As a retiree, your dependents are eligible to continue NYSHIP coverage as dependent survivors if:
 - They are covered on your family coverage at the time of your death;
OR
 - You deferred your health insurance coverage and had family coverage in effect at the time of deferral,
AND
 - You had 10 years of benefits-eligible service.



To Initiate Dependent Survivor Coverage

- Dependent must notify Employee's Retirement System of death;

OR

- Dependent must notify EBD (Dept. of Civil Service) and provide copy of death certificate.

EBD will send survivor(s) information about continuing coverage.

What is the cost for Dependent Survivor Coverage?

- Most dependent survivors:
 - Dependent survivor pays 10% of the total cost of individual coverage.
 - If dependent survivor maintains family coverage, they pay 25% of total cost.

- If selected by the retiree (prior to retirement), Dual Annuitant Sick Leave Credit remains in effect and offsets the cost of dependent survivor's coverage.

Dependent Survivor Coverage

- Permanently ends if your dependent survivor:
 - Does not elect to continue coverage
 - Remarries or repartners
 - Cancels coverage
 - Fails to make premium payments
 - Ages out or otherwise loses dependent eligibility (child's 26th birthday)

- Eligibility rules for children are the same as when they are enrolled under your coverage, generally only children enrolled at the time of your death are eligible.

Medicare

What is Medicare?

- The federal health insurance benefits program administered by the Centers for Medicare & Medicaid Services (CMS).

When Does Medicare Eligibility Begin?

- At age 65. (It becomes effective on the first day of the month you turn 65, or the first day of the month prior to your birthday if your birthday is on the first of the month.)

Note: **Enroll 3 months before your 65th birthday**

- After two years of SSDI (Social Security Disability Insurance) eligibility
- When diagnosed with end-stage renal disease
- When enrolled in SSDI due to Amyotrophic Lateral Sclerosis (ALS) (Medicare eligibility available immediately upon diagnosis)



Medicare – Part A and Part B

(Original Medicare)

- **Part A** provides inpatient hospital coverage, skilled nursing facility and hospice care. It is free if you meet the Social Security work requirements.
- **Part B** provides outpatient hospital and medical coverage, doctor services, durable medical equipment, other services not covered by Part A. There is an enrollee premium for Part B.

Medicare – Part C and Part D

- Medicare Advantage Plans (**Part C**)
 - Your Medicare coverage is combined with the HMO.
 - You must live or work in the approved service area.
 - Coverage outside the provider network or service area must be preauthorized by the HMO.
 - You have no standalone Medicare coverage.

- **Part D** provides prescription drug coverage.



Medicare and NYSHIP

- NYSHIP **requires** you to be enrolled in Medicare Parts A and B when Medicare is primary.
- When Medicare is primary, enrollees are reimbursed for the standard monthly Part B premium for each Medicare-primary person covered under the contract.

When is Medicare Primary to NYSHIP?

Still Working?

- For enrollees or dependents with End Stage Renal Disease who are no longer in the 30-month coordination period
- For your covered domestic partner who turns 65

Retired!

- For you (if Medicare eligible)
- For your Medicare-eligible dependents



Enrolling in Medicare

- It is **YOUR** responsibility to enroll in Medicare Parts A and B when first eligible for primary Medicare coverage.
- Contact Social Security Administration (www.ssa.gov/retire):
 - At least 3 months prior to retiring, when you or your dependent will be age 65 or over or eligible due to disability at the time of your retirement.
 - At least 3 months prior to attaining Medicare eligibility due to age or disability after you retire.
- Civil Service, Employee Benefits Division will update your enrollment record with your health plan.

Form CMS-L564 (CMS-R-297)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer's Name _____ 2. Date _____

3. Employer's Address _____

City _____ State _____ Zip Code _____

4. Applicant's Name _____ 5. Applicant's Social Security Number _____

6. Employee's Name _____ 7. Employee's Social Security Number _____

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

1. Is (or was) the applicant covered under an employer group health plan? ☐ Yes ☐ No

2. If yes, give the date the applicant's coverage began. (mm/yyyy)
_____/_____/_____

3. Has the coverage ended? ☐ Yes ☐ No

4. If yes, give the date the coverage ended. (mm/yyyy)
_____/_____/_____

5. When did the employee work for your company?
From: (mm/yyyy) _____ To: (mm/yyyy) _____ Still Employed: (mm/yyyy) _____

6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.
From: (mm/yyyy) _____ To: (mm/yyyy) _____

For Hours Bank Arrangements ONLY:

1. Is (or was) the applicant covered under an Hours Bank Arrangement? ☐ Yes ☐ No

2. If yes, does the applicant have hours remaining in reserve? ☐ Yes ☐ No

3. Date reserve hours ended or will be used? (mm/yyyy)
_____/_____/_____

All Employers:

Signature of Company Official _____ Date Signed _____

Title of Company Official _____ Phone Number _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0787. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimated or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

Form CMS-L564 (CMS-R-297) (09/16)

STEP BY STEP INSTRUCTIONS FOR THIS FORM

SECTION A:

The person applying for Medicare completes all of Section A.

- Employer's name:**
Write the name of your employer.
- Date:**
Write the date that you're filling out the Request for Employment Information form.
- Employer's address:**
Write your employer's address.
- Applicant's Name:**
Write your name here.
- Applicant's Social Security Number:**
Write your Social Security Number here.
- Employee's Name:**
If you get group health plan coverage based on your employment, write your name here. If you get group health plan coverage through another person, like a spouse or family member, write their name.
- Employee's Social Security Number:**
If you get group health plan coverage based on your employment, write your Social Security Number here. If you get group health plan coverage through another person, like a spouse or family member, write their Social Security Number.

Once you complete Section A:
Once Section A is completed, give this form to your employer to complete Section B. Once Section B has been completed by your employer, return this form along with your Part B application to your local Social Security office.

SECTION B:

The employer completes all of Section B.

If you're an employer without an hours bank arrangement, complete the section called "For Employer Group Health Plans ONLY"

- Is (or was) the applicant covered under an employer group health plan?**
Please check yes or no if the applicant was covered under your group health plan offered by your company. The applicant may be the employee or another person related to the employee, such as a spouse or family member with disabilities. If your company doesn't offer a group health plan, please check No. A group health plan is any plan of one or more employers to provide health benefits or medical care (directly or otherwise) to current or former employees, the employer, or their families.
- If yes, give the date the coverage began.**
Write the month and year the date the applicant's coverage began in your group health plan.
- Has the coverage ended?**
Check yes or no if the group health plan coverage for the applicant has ended.
- If yes, give the date the coverage ended.**
Write the month and year the group health plan coverage ended for the applicant.

5. When did the employee work for your company?

- Write the start and end dates of the employment for the employee in which the applicant is related. It may be the applicant or another person related to the employee, such as a spouse or family member with disabilities. Enter the month and year of the start of the employment in the "From" box. Enter the month and year of end of the employment in the "To" box. If the employee is still employed, enter the month and year of the current date. Current employment is active working status. It is not disability or retirement.
- 6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.**
Write the start and end dates that your group health plan was primary payer for the applicant.

If you're an employer with an hours bank arrangement, complete the section called "For Hours Bank Arrangements ONLY"

- Is (or was) the applicant covered under an hours bank arrangement?**
Please check yes or no if the applicant was covered under an hours bank arrangement. If you check no, please also fill out the section for "Employer Group Health Plans ONLY."
- If yes, does the applicant have hours remaining in reserve?**
Please indicate if the applicant currently has health coverage based on the remaining hours in the employee's hours bank account.
- Date reserve hours ended or will be used?**
Please write the month and year for when the remaining hours in the employee's hours bank account expired or will expire.

All employers need to complete the bottom of Section B.

- Signature of Company Official:**
An official representative of the company needs to sign this document. Please do not print.
- Date Signed:**
Write the date that you sign the form in this field.
- Title of Company Official:**
Print the title of the company official who signed the form in this field.
- Phone Number:**
Write the phone number of the company official who signed the form in this field. If there are questions regarding the information on this form, a representative from Social Security will contact you.

➤ Provided with your Retirement Packet from BSC Benefits is you or your dependents are 65.

➤ BSC Benefits completes section B

➤ Employees over 65 should submit to Social Security Administration to enroll in Medicare 3 months prior to retirement



Office of
Social Services

Medicare and NYSHIP Benefits

Each Medicare-primary enrollee and dependent is reimbursed for standard Part B Premium. The Standard Medicare Part B premium is reimbursed on a monthly-quarterly basis.

Reimbursement for Medicare Part B

- If you are required to pay a higher Part B Premium based on your income (IRMAA), you can apply for reimbursement for your additional costs.

Medicare Part B & D IRMAA (Income-Related Monthly Adjustment Amount)

- If you are required to pay a Medicare Part B IRMAA, that amount will be included in your Social Security annual award letter sent by the Social Security Administration.
- If eligible, NYSHIP will reimburse you for this amount on an annual basis.
- NYSHIP will not reimburse IRMAA premiums assessed for Medicare Part D.



Medicare and NYSHIP Benefits (Continued)

- When you or your dependents become Medicare eligible prior to age 65, notify Civil Service's Employee Benefits Division (EBD).
- EBD will need:
 - A copy of your Medicare ID card;
 - Your physical street address, if you only have a PO Box on file.

Note: EBD will mail correspondence to a PO Box but a physical address must be maintained.



The Empire Plan and Medicare

- Most claims submitted to Medicare first are then automatically sent to the Empire Plan for additional consideration.
- Most enrollees and dependents are automatically enrolled in crossover with UnitedHealthcare.

NYSHIP HMOs and Medicare

- A few NYSHIP HMOs used to coordinate benefits with Original Medicare (Parts A and B) this is no longer the case as of plan year 2018.
- Now all NYSHIP HMOs provide Medicare Advantage Plans (Part C) for enrollees and/or dependents with Medicare as primary coverage.
 - Under these plans, you receive both your Medicare and NYSHIP benefits from that plan.
 - Care received outside of the HMO is only covered to the extent the HMO allows.



Your Prescription Drug Benefit

- All NYSHIP enrollees and their dependents have prescription drug coverage as part of their health insurance coverage.
- Prescription coverage continues even when Medicare becomes the primary coverage.
- When enrolled in Medicare and NYSHIP drug coverage is provided through a Medicare Part D plan. This coverage pays on average as much or more than Medicare's standard Part D Plan. This is called creditable coverage.

Empire Plan Medicare Rx

- **REQUIRED** for Medicare-primary enrollees and dependents enrolled in The Empire Plan.
- EBD will automatically begin the enrollment process for Medicare-primary enrollees and dependents into Empire Plan Medicare Rx.

Medicare Summary

- Enroll when first eligible for Parts A and B
 - Ensures claims are paid correctly.
 - Assists enrollment in Empire Plan Medicare Rx or NYSHIP Advantage HMO (Part C).
- If you enroll in a Medicare product outside NYSHIP, this will **cancel** your NYSHIP (Empire Plan or Medicare Advantage Plans) benefits for you and any covered dependents.
- Call EBD at 1-800-833-4344 before you become eligible or if you have any questions about Medicare and NYSHIP.
- Additional information available:
 - Social Security Administration www.ssa.gov/retire
 - NYS Dept. of Civil Service www.cs.ny.gov



If You Return to State Service

- In a benefits-eligible position (50% or more, 6 consecutive pay periods) you may:

- Continue with retiree benefits

OR

- Return to active benefits

- If Medicare eligible:

- NYSHIP becomes primary
- Medicare Part B reimbursement ends



Option Changes

- Option transfer is permitted one time per 12-month period.
- You will receive notification of rate changes prior to the end of the plan year.
- Benefits information is available on the Department of Civil Service web site at: www.cs.ny.gov

Health Benefits when Traveling or Moving

➤ Traveling

- Reach out to your HMO or Empire Plan regarding coverage while traveling.

➤ Moving

- NYSHIP HMO's – outside your HMO area
 - You must change your benefit plan to either the Empire Plan, or a NYSHIP HMO in that area.
- Empire Plan – visit Civil Service's website at www.cs.ny.gov/retirees for a listing of providers in that area or call Empire plan 1-877-769-7447.
- Living outside the United States – **Medicare does not provide coverage outside the United States.** You will need to reach out to Civil Service at 1-800-833-4344, to ensure NYSHIP primary. Medicare reimbursement **stops** for retirees living outside the United States.



Dental & Vision



Post-Retirement Dental & Vision Benefits

- Some State employees receive these benefits under NYSHIP (PEF, M/C, NYSCOPBA) and others through a union's Employee Benefits Fund (CSEA, DC-37).
- Under NYSHIP, (PEF, M/C, NYSCOPBA) benefits end 28 days after the last day of the payroll period in which you worked.
- Under union benefits fund (CSEA, DC-37) benefits end 28 days after the last day of the last day of work.
- If you want to continue dental and vision benefits after retirement, you will pay the full cost.
- If enrolled, you will automatically receive COBRA (up to 36 months) application from the Department of Civil Service when benefits end.



Post-Retirement Dental/Vision Benefits (Continued)

Dental

- COBRA (up to 36 months)
 - Union Employee Benefit Fund (CSEA, DC-37)
 - State Program (PEF, M/C, NYSCOPBA)
- May choose to convert to GHI Retirement Plan

Vision

- COBRA (up to 36 months)
 - Union Employee Benefit Fund (CSEA, DC-37)
 - State Program (PEF, M/C, NYSCOPBA)

Additional plans may be available through unions, contact your union for details.



After You Retire...

- Civil Service's EBD becomes your contact for benefits related questions/changes.
- All enrollment changes must be requested **in writing** and signed by the enrollee.
 - Address changes
 - Dependent changes
 - Option changes

New York State Department of Civil Service
Employee Benefits Division
Empire State Plaza
Swan Street Building (Core 1) First Floor
Albany, NY 12239

(518) 457-5754 or (800) 833-4344
www.cs.ny.gov/employee-benefits



Office of
General Services

Questions?

Contact Us

BSCBenefitsAdmin@ogs.ny.gov

(518) 457-4272

BSC Benefits Unit
W. Averell Harriman State Office Campus
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