



**10. Continued. ENTER REQUEST(S) BELOW**

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

I. Change Pre-Tax Status      Change to:  Pre-Tax    Post-Tax      Processed only by the Employee Benefits Division during the Pre-Tax Contribution Selection Period (November)

**11. PREVIOUS COVERAGE INFORMATION**

If you were previously enrolled in a NYSHIP plan, or were covered another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.	Previous ID Number	Date the other coverage terminated		
	Enrollee's Name Under Which Previously Covered	Last	First	Middle Initial

**12. LEAVE WITHOUT PAY AND RETIREMENT STATUS**

**LEAVE WITHOUT PAY**

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

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

**RETIREMENT**

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

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

**13. REQUEST FOR EMPIRE PLAN CARD ONLY**

For Health Maintenance Organization (HMO) cards, contact your HMO.

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

**Personal Privacy Protection Law Notification**

The information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 457-9375. For information related to the Health Insurance Program, contact your Agency Health Benefits Administrator. If, after calling your Agency Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

**AUTHORIZATION**

I have read the Pre-Tax Contribution Program memorandum and have made my selection on Page 1 of this document, if applicable. I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving State service (vest, retirement, etc.). I certify that the information I have supplied is true and correct. I understand that my failure to provide required proof(s) within 28 days (30 days for newborns) may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims. I hereby authorize deduction from my salary or retirement allowance of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

→ Employee's Signature (Required) \_\_\_\_\_ Signature Date (Required) \_\_\_\_\_

**AGENCY/EBD USE ONLY**

Action/Reason	Date of Event	Hire Date	Date of 1 <sup>st</sup> Eligibility (PE only)	Percentage Working	Agency Code	Neg. Unit	Ret. System
Retirement Tier	Registration #	Sick Leave Information		Date Entered on NYBEAS	Effective Date		
	<input type="checkbox"/>	# Hours	Hourly Rate of Pay				

**HBA Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_