

State of New York Department of Civil Service Alfred E. Smith State Office Bldg. Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

PA HEALTH INSURANCE TRANSACTION FORM

PS-503.1 (2/07L)

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

EMPLOYEE INFORMATION (All employees must complete)												
1 Last Name	First	Name	MI 2 3	Social S	Security Number	3 Sex						
4 Street Address		City			State	Zip						
5 Date of Birth 6 Tele Home (phone Numbers		7 Work location and address									
Home () Work () 8 Marital Status												
Single Widowed Separated												
9 Covered under Medicare? Self Yes No Spouse/Domestic Partner Yes No Dependent Yes No												
A. Request Enrollment- For Agency Use: (Select Empire Plan Option)												
A. Request Enrollment- Individual					acy Use: (Select Empire Plan Option) s med & psych) 8 (core only)							
B. Request Enrollment- Family (Complete G)	List dependents in section G		For Agency Us (core plus med &	agency Use: (Select Empire Plan Option) plus med & psych) 8 (core only)								
C. Decline Coverage	For Agency Use only: Process waive benefits transaction											
D. Voluntarily Cancel Coverage												
E. Name Change	nange Previous Name was:											
F. Change Coverage Date of Event												
Change to FAMILY (Complete G) ☐ Marriage ☐ I voluntarily cancel coverage for my dependents ☐ Domestic Partner ☐ I voluntarily cancel coverage for my domestic partner ☐ First dependent child acquired ☐ Only dependent died ☐ Dependent returned to full-time student status ☐ Only dependent married ☐ Request coverage for dependents not previously covered ☐ Only dependent graduated ☐ Newborn ☐ Divorce ☐ Previous coverage terminated (Complete Section 11) ☐ Only dependent disqualified by age ☐ Termination of domestic partnership (Attach Completed PS) ☐ Other ☐ Other						artner						
G.	D	EPENDENT II	NFORMATIO	N	(use additional	sheets if necessary)						
Check One: A (Add), D (Delete), C (Change), Medicare (M) Date of Event Is enrollee or spouse reimbursed by another agency? Yes \[\subseteq No												
Last Name	First Name MI	Relationship	Date of Birth	Sex	Address (if differen	Social Security #						
□ A □ D □ M □ C												
□ A □ D □ M □ C												
□ A □ D □ M □ C												
□ A □ D □ M □ C												
□ A □ D □ M □ C												

10 Cont'd ENTER REQUEST(S) BELOW												
H. Change Retiree Pa	hange Retiree Payment status Change to: pension deduction (Rate/) direct payment to agency (APAY)											
I. Correct Social Security Number Incorrect SSN:												
11 PREVIOUS COVERAGE INFORMATION												
If you were previously covered under NYSHIP or another health insurance plan (attach proof, i.e. insurance bill or letter)												
stating former coverage) this section.		Enrollee's Name Which Previousl			First	M10	ddle Initial					
12 LEAVE WITHOUT PAY AND RETIREMENT STATUS												
I wish to continue coverage while I am on authorized leave. LEAVE WITHOUT PAY I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll.												
I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue												
RETIREMENT/ my coverage. VESTEE STATUS I understand the requirements for continuing medical insurance coverage as a vestee and wish to continue my coverage.												
13 REQUEST FOR EMPIRE PLAN CARD												
□ DUPLICATE CARD (Previously issued card remains valid.) □ REPLACEMENT CARD (Previously issued card(s), lost or stolen, become invalid.) □ REPLACEMENT CARD (Previously issued card(s), lost or stolen, become invalid.) FOR							TS					
Personal Privacy Protection Law Notification This information you provide on this application is being requested pursuant to Section 163 of the New York State Civil Service Law for the purpose of enabling the NYS 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 your Personnel Office and by the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For further information relating <i>only</i> to 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 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 agency 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 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 misstatement of fact or conceals any pertinent information, commits a crime which is subject to a \$5,000 penalty and the stated value of the claim for each violation. 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)												
		AGENC	Y/EBD USE ONLY									
Action/Reason	Date of Event	Hire Date	First Eligibility Date	Agency Code	Date Eligibi Lost	ility	Retirement System					
Retirement Tier Registration #		Pension I	Deductions	Date Entered on	Date Entered on NYBEAS Effective		Effective Date					
	- 0	Yes										
HBA Signature:						Date:						