NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE BENEFITS DIVISION

NYSHIP Health Insurance Transaction Form

for the Student Employee Health Plan (SEHP)

PS-404G (1/2023)

INSTRUCTIONS: READ AND COMPLETE BOTH PAGES. PLEASE PRINT, CHECK THE APPROPRIATE CHOICES AND SIGN/DATE THE DOCUMENT.

EMPLOYEE INFORMATION

1. Last Name / First Name / MI		**2.** Social Security Number	**3.** Gender ☐ F ☐ M ☐ X
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. Personal Email Address:			
10. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated		Marital Status Date: _____	
11. Covered under Medicare? ☐ Self	Medicare ID Number: _____	Date: _____	
☐ Dependent	Medicare ID Number: _____ Dependent Name: _____	Date: _____	
12. Is any of this information new? ☐ No ☐ Yes	Box Number(s): _____	Effective Date of Change: _____	

13. ELECT OR DECLINE COVERAGE

A. Select a SEHP Coverage Option

- ☐ **Individual Enrollment**
- ☐ **Family Enrollment** *(Complete box 14)*
- ☐ **Decline Coverage**

B. Choose a Pre-Tax election

You are only eligible for Pre-Tax deductions if newly eligible or if requested during the Pre-Tax Contribution Program (PTCP) Election Period

- ☐ **Elect Pre-Tax Status** for Premium deduction
- ☐ **Elect After-Tax Status** for Premium deduction

14. DEPENDENT INFORMATION

Must be provided when choosing to enroll in family coverage *(use additional sheets if necessary)*

Check One: A (Add), D (Delete) or C (Change) **Date of Event:** _____

↓	Last Name / First Name / MI	Relationship	Date of Birth	Gender	Address *(if different)*	Social Security Number
☐ A ☐ D ☐ C				☐ F ☐ M ☐ X		
☐ A ☐ D ☐ C				☐ F ☐ M ☐ X		
☐ A ☐ D ☐ C				☐ F ☐ M ☐ X		
☐ A ☐ D ☐ C				☐ F ☐ M ☐ X		

15. CHANGE OR CANCEL EXISTING COVERAGE

A. Change Coverage

Date of Event: _____

☐ **Change to FAMILY** *(Complete box 14 on page 1)*

- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Arrival of eligible dependent in United States
- ☐ Other: _____

☐ **Change to INDIVIDUAL**

- ☐ Divorce
- ☐ Termination of Domestic Partnership *(Attach completed PS-425.4)*
- ☐ Only dependent ineligible due to age
- ☐ I voluntarily cancel coverage for my dependents
- ☐ Only dependent died
- ☐ Other: _____

NOTE: If you are indicating a change in marital status to Divorced or Separated in box 10, please be sure to update the address information for the dependent in box 14 on page 1 if applicable.

B. Voluntarily Cancel Coverage: ☐ Qualifying Event: _____ Event Date: _____

NOTE: If you are enrolled in the Pre-Tax Contribution Program, you may make changes during the PTCP Election Period or when experiencing a qualifying event.

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, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

AUTHORIZATION

I have read the Pre-Tax Contribution Program materials 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 SEHP. 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 of the amount required for the coverage indicated above.

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

AGENCY USE ONLY

Hire Date	Percentage Working	Agency Code	Neg. Unit	Action/Reason	Date of Event	Effective Date

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