NEW YORK STATE OF OPPORTUNITY. **Department of Civil Service**

EMPLOYEE BENEFITS DIVISION
PA HEALTH INSURANCE TRANSACTION FORM

PS-503 (6/16)

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 ☐ Male ☐ Female	
4. Mailing Address (If PO Box, complete box 5)	City	State	Zip
5. Home Address (If different from mailing address)	City	State	Zip
6. Date of Birth	**7.** Telephone Numbers Home ( ) Work ( )	**8.** Work location and address	
9. Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated	Marital Status Date		

10. DEPENDENT INFORMATION

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

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

	Last Name First Name MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security Number
☐A ☐D ☐C ☐M						
☐A ☐D ☐C ☐M						
☐A ☐D ☐C ☐M						
☐A ☐D ☐C ☐M						

11. MEDICARE INFORMATION

A. Covered under Medicare? ☐ Self Medicare ID Number: _____
☐ Dependent Name: _____ Medicare ID Number: _____

B. Is enrollee or dependent reimbursed for Medicare by another entity? ☐ Self ☐ Dependent

12. NEW OR NEWLY ELIGIBLE EMPLOYEES: CHOOSE ONE OF THE FOLLOWING OPTIONS (A OR B)

C. Enroll in New York State Health Insurance Plan (NYSHIP) Coverage: Choose options 1 or 2

1. **Individual Enrollment**	☐ Empire Plan	☐ Excelsior Plan
2. **Family Enrollment** *(Complete box 10)*	☐ Empire Plan	☐ Excelsior Plan

D. Decline New York State Health Insurance Plan (NYSHIP) Coverage ☐

13. TO CHANGE OR CANCEL COVERAGE CHOOSE FROM THE BOXES BELOW

A. Change Coverage: Qualifying Event: _____ Date of Event: _____

☐ **Change to FAMILY** *(Complete box 10)*

- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Dependent returned to full-time student status
- ☐ 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: _____

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

14.	CORRECT SOCIAL SECURITY NUMBER	
Correct Social Security Number	Incorrect SSN: _____	Correct SSN: _____

15.	PREVIOUS COVERAGE INFORMATION			
If you were previously covered under NYSHIP or another health insurance plan, please complete this section and attach proofs (i.e. insurance bill or letter stating former coverage).	Previous ID Number: _____		Date Coverage Terminated:	
	Enrollee's Name Under Which Previously Covered	Last Name	First Name	MI

16.	RETIREMENT STATUS	
Retirement/ Vestee Status	☐	I understand the requirements for continuing coverage as a retiree or vestee and wish to continue my coverage.
	☐	I understand the requirements for continuing coverage as a retiree or vestee and wish to defer my coverage.
Change Retiree Payment Status	Change to:	☐ Pension Deduction (Rate: _____ / _____) ☐ Direct Payment to Agency

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 Health Benefits Administrator**. If, after calling your 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 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 1st Eligibility	Percentage Working	Agency Code

Eligibility Lost Date	Retirement System	Retirement Tier	Registration #	Date Entered on NYBEAS	Effective Date

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