



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
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: Yes No Spouse/Domestic Partner: Yes No Child: Yes No

12. ELECT OR DECLINE COVERAGE

A. Select a SEHP Coverage Option
B. Choose a Pre-Tax election
(Only eligible for Pre-Tax deductions if newly eligible or if requested during the PTCP election period)

13. CHANGE OR CANCEL EXISTING COVERAGE

A. Change Coverage: Date of Event:
Change to FAMILY (Complete box 14) Change to INDIVIDUAL
Marriage Divorce
Domestic Partner Termination of Domestic Partnership (Attach completed PS-425.4)
Newborn Only dependent ineligible due to age
First dependent child acquired Only dependent died
Arrival of eligible dependent in United States Only dependent married
Request coverage for dependents not previously covered I voluntarily cancel coverage for my dependents
Previous coverage terminated (proof required) I voluntarily cancel coverage for my domestic partner
Other: 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 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 Annual Open Enrollment Period or when experiencing a qualifying event.

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	Sex	Address (if different)	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C								
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C								
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C								

Personal Privacy Protection Law Notification

The information you provide on this application is requested in accordance with Section 163 of 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

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): Jane Smith Date: _____

AGENCY USE ONLY

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

HBA Signature (Required): _____ Date: _____