



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
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: Date:
Dependent Name:
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:
Table with columns: Last Name, First Name, MI, Relationship, Date of Birth, Gender, Address (if different), Social Security Number

15. CHANGE OR CANCEL EXISTING COVERAGE

A. Change Coverage Date of Event: _____

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

<input type="checkbox"/> Marriage <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Newborn <input type="checkbox"/> Request coverage for dependents not previously covered <input type="checkbox"/> Previous coverage terminated <i>(proof required)</i> <input type="checkbox"/> Arrival of eligible dependent in United States <input type="checkbox"/> Other: _____	<input type="checkbox"/> Divorce <input type="checkbox"/> Termination of Domestic Partnership <i>(Attach completed PS-425.4)</i> <input type="checkbox"/> Only dependent ineligible due to age <input type="checkbox"/> I voluntarily cancel coverage for my dependents <input type="checkbox"/> Only dependent died <input type="checkbox"/> Other: _____
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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:** _____

Documentation Requirements for the Student Employee

Completed enrollment form
A copy of your birth certificate or passport
A copy of your Social Security Card
A copy of your appointment letter

Documentation Requirements for Dependents

A copy of their birth certificate or passport
A copy of their Social Security Card (if they have a Social Security Number)
If adding a spouse, a copy of your marriage certificate

Documentation Requirements for Domestic Partners

Completed and notarized [NYSHIP Domestic Partner Enrollment Form](#)
A copy of their birth certificate or passport
A copy of their Social Security Card (if they have a Social Security Number)
The additional documentation listed in Section B of the NYSHIP Domestic Partner Enrollment Form

Section 13.B. - Pre-Tax / After Tax Deductions

If you enroll with pre-tax premium deductions, your health insurance premiums will be deducted before you are taxed on your income, so you will be taxed on a lesser amount. Electing pre-tax deductions, however, will prohibit you from cancelling coverage or changing from family to individual coverage outside of the annual option transfer period without a qualifying event (e.g. acquiring new health insurance coverage from another source). After-tax deductions will allow you to voluntarily make the above changes anytime during the year.

15.B.- Voluntarily Cancellation of Coverage

If you are enrolled with pre-tax deductions, you will need to provide documentation from your new insurance company or employer that confirms that you have become newly eligible or and acquired new health insurance coverage within the 30 days prior to your cancellation request. Otherwise, you will need to request cancellation of coverage during the annual Option Transfer Period (usually held in December). If you are enrolled with after-tax deductions, you may voluntarily cancel your coverage at any time.