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: _____ 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:** _____

↓	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:** _____

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.