State of New York
Department of Civil Service
Alfred E. Smith State Office Bldg.
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

INSTRUCTIONS FOR THE PS-404
NYS HEALTH INSURANCE TRANSACTION FORM

PS-404 I (1/07)

Boxes 1 - 9	All enrollees must complete boxes 1 – 9 with their personal information. Note: Marital Status Date is used to show date of marriage, separation or divorce when those marital statuses are selected.

Box 10 (A – I)	Complete appropriate sections. The employee is entitled to make separate choices regarding their medical, dental and vision coverages. They may decline any of the three, all of the three, or none of the three different coverage options. Also, they many enroll in family coverage in one benefit and individual coverage in another. Reminder: Enrollees with a Benefit Fund (CSEA, UUP and DC-37) receive their dental and vision benefits through that Fund. **Do not** enter dental and vision information on NYBEAS for these enrollees.

New Enrollees (also complete 10.G for family coverage)

Note: for new enrollments in a Health Maintenance Organization (HMO), complete an HMO form in addition to this form.

10.A	Request Enrollment – Individual	Check box to enroll in individual coverage. Check Medical, Dental and/or Vision boxes for coverage being enrolled.
10.B	Request Enrollment – Family	Check box to enroll in family coverage. Check Medical, Dental and/or Vision boxes for coverage being enrolled.
10.C	Elect Pre-Tax Status?	New Enrollees choose to enroll in or decline the Pre-Tax Contribution Program for medical coverage.
10.D	Decline Coverage	Check box to decline coverage. Check Medical, Dental and/or Vision boxes for coverage being declined.

Cancellation or Change in Coverage

10.E	Voluntarily Cancel Coverage	The enrollee is entitled to make separate decisions regarding their medical, dental and vision coverages. Enrollees may cancel or change their dental and/or vision coverage(s) at any time during the year. Pre-tax medical enrollees may only cancel coverage during the Pre-Tax Open Enrollment Period, or with a qualifying event (enter the qualifying event). If you are going on **Leave Without Pay, also complete Box 12**.
10.F	Change Coverage	Check this box to change from Individual to Family, or from Family to Individual coverage. Pre-tax medical enrollees may only change their coverage from Family to Individual during the Pre-Tax Open Enrollment Period, or with a qualifying event (check the qualifying event and enter the Date of Event). Check Medical, Dental, and/or Vision boxes for coverage being changed.
10.G	Add/Change/Delete Dependents	Check the box to add or delete dependents or to change dependent information. Check Medical, Dental, and/or Vision boxes that apply. Complete all dependent information including **date of birth**. Additional documentation may be required to add the dependent.
10.H	Change Medical Benefit Plan	Complete during annual Option Transfer Period or with a qualifying event (for example, change of address outside of HMO area.)
10.I	Change Pre-Tax Status	Existing enrollees can only change pre-tax status during the annual Pre-Tax Open Enrollment Period in November.

Box 11	Complete previous coverage information, if applicable.

Box 12	LEAVE WITHOUT PAY SECTION	Enrollees going on leave without pay who request cancellation of coverage at the time they leave the payroll must complete this section. To request permanent cancellation of coverage, check the appropriate box and cross out the sentence which reads "I wish to resume my coverage upon return to the payroll."
	RETIREMENT SECTION	Enrollees leaving the payroll due to retirement must complete this section to indicate their decision to either defer or continue health insurance coverage as a retiree. A PS-406.2 must be completed for enrollees requesting deferment of medical coverage, prior to retirement.

Box 13	Request for Empire Plan Cards Only – complete this section to order a duplicate or replacement Benefit Card. **Do not** complete this section if requesting a change to your health insurance coverage. A new card will be issued automatically.

AUTHORIZATION	Employees must SIGN and DATE this form.

AGENCY/EBD USE ONLY	This section is for Agency and/or EBD use only and is provided to assist in updating the enrollee's record on NYBEAS.
Action/Reason	Transaction that will be inputted into NYBEAS by HBA.
Date of Event	Date the event took place, which resulted in the enrollee requesting a change to benefits. Example: first day worked, first day on leave, date of birth, date of marriage.
Hire Date	Original date of hire or rehire. (Only needed for new enrollment).
Date of 1st Eligibility (PE only)	The first day the enrollee is eligible for coverage.
Percentage Working	Enrollee's percentage on payroll.
Agency Code	Enrollee's agency code.
Neg. Unit	Enrollee's negotiating unit.
Ret. System	The retirement system for the enrollee (ERS, TRS or PFS)
Retirement Tier	Tier 1, 2, 3 or 4.
Sick Leave Information - # Hours	Number of sick leave hours for enrollee at time of retirement.
Sick Leave Information - Hourly Rate of Pay	Enrollee's hourly rate of pay based on annual salary at the time of retirement. (See Hourly Rate Calculation memo NY99-22).
Date Entered on NYBEAS	Date HBA processes the transaction on NYBEAS.
Effective Date	The effective date assigned to the transaction by NYBEAS.

Note: When updating NYBEAS, use **Date** in **Authorization Box** as **Date of Request**.
Legal changed

EXAMPLES OF DOCUMENTATION REQUIRED TO PROCESS YOUR TRANSACTION

Employees	**Spouse/Domestic Partner**	**Children**
Copy of Birth Certificate	Copy of Birth Certificate	Copy of Birth Certificate
Copy of Social Security Card	Copy of Social Security Card	Copy of Social Security Card
	Copy of Marriage Certificate or Complete PS-425 series Domestic Partner, if Applicable	Completed PS-451 – Statement of Disability and Required Documentation, if Applicable
	For Changes of Coverage, copy of Marriage Certificate, Divorce Order, Death Certificate, PS-425.4 (Domestic Partner), as appropriate	Completed PS-457 – Statement of Dependence and Required Documentation, if Applicable

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EMPLOYEE BENEFITS DIVISION

NYS HEALTH INSURANCE TRANSACTION FORM

For Participating Employers PS-404 PE (1/07)

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. Street Address City State Alabama Zip		
5. Date of Birth	**6.** Telephone Numbers Home ( ) Work ( )	**7.** Work location and address
8. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Marital Status Date	
9. Covered under Medicare? Self ☐ Yes ☐ No	Spouse/Domestic Partner/Dependent? ☐ Yes ☐ No	

10. ENTER REQUEST(S) BELOW

A. ☐ Request Enrollment- **Individual**	*(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO* Code ☐ Name
B. ☐ Request Enrollment- **Family** (Complete G)	*(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO* Code ☐ Name
C. ☐ Elect Pre-Tax Status for Premium deduction?	☐ Yes ☐ No Note: pretax deductions may not be offered by all agencies. Verify eligibility with your agency.
D. ☐ Decline Coverage	*For Agency Use: (Process WAV/BEN transaction)*
E. ☐ Voluntarily Cancel Coverage	

F. ☐ Change Coverage **Date of Event** _____

☐ **Change to FAMILY** *(Complete G)*

- ☐ Marriage
- ☐ Domestic Partner
- ☐ First dependent child acquired
- ☐ Dependent returned to full-time student status
- ☐ Request coverage for dependents not previously covered
- ☐ Newborn
- ☐ Previous coverage terminated *(Complete Section 11)*
- ☐ Other _____

☐ **Change to INDIVIDUAL**

- ☐ I voluntarily cancel coverage for my dependents
- ☐ I voluntarily cancel coverage for my domestic partner
- ☐ Only dependent died
- ☐ Only dependent married
- ☐ Only dependent graduated
- ☐ Divorce
- ☐ Only dependent disqualified by age
- ☐ Termination of domestic partnership *(Attach Completed PS-428.4)*
- ☐ Other _____

G. **DEPENDENT INFORMATION** *(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
☐ A ☐ D ☐ C				F		
☐ A ☐ D ☐ C				F		
☐ A ☐ D ☐ C				F		
☐ A ☐ D ☐ C				F		
☐ A ☐ D ☐ C				F		

**** A completed HMO form must be attached.***

10. *Continued*. **ENTER REQUEST(S) BELOW**

H. ☐ Change Medical Benefit Plan Change to: ☐ Empire Plan ☐ HMO * Code ____ HMO Name _____
* A completed HMO form must be attached.

11. PREVIOUS COVERAGE INFORMATION

If you were previously covered under NYSHIP or another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.

Previous ID Number	Date Coverage Terminated
Enrollee's Name Under Which Previously Covered — Last / First / Middle Initial	

12. LEAVE WITHOUT PAY AND RETIREMENT STATUS

LEAVE WITHOUT PAY

☐ I wish to continue coverage while I am on authorized leave.
I understand that I will be billed for this coverage.

☐ I do not wish to continue coverage while I am on authorized leave.
I wish to resume my coverage upon return to the payroll.

RETIREMENT

☐ I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage.

☐ I understand the requirements for continuing medical insurance coverage as a retiree and wish to defer my coverage. *(A completed PS-406.2 must be attached.)*

13. REQUEST FOR EMPIRE PLAN CARD ONLY

For Health Maintenance Organization (HMO) cards, contact your HMO.

☐ DUPLICATE CARD
(Previously issued card remains valid.)
☐ REPLACEMENT CARD
(Previously issued card(s), lost or stolen, become invalid.)

FOR
☐ ENROLLEE
☐ ENROLLEE AND ALL DEPENDENTS
☐ INDIVIDUAL DEPENDENT
Name _____

Personal Privacy Protection Law Notification

This 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 Agency Health Benefits Administrator**. If, after calling your Agency 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 3:00 p.m.

AUTHORIZATION

I have read the Pre-Tax Contribution Program memorandum and have made my selection on Page 1 of this document, if applicable. I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving State service (vest, retirement, etc.). **I certify that the information I have supplied is true and correct.** I understand that my failure to provide required proof(s) within 28 days (30 days for newborns) may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a misstatement of fact or conceals any pertinent information, commits a crime which is subject to a $5,000 penalty *and* the stated value of the claim for *each* violation. I hereby ***authorize deduction from my salary or retirement allowance*** of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

→ Employee's Signature **(Required)** _____ Signature Date **(Required)** _____

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	Date of 1st Eligibility	Percentage Working	Agency Code	Neg. Unit	Ret. System

Retirement Tier	Registration #	Sick Leave Information # Hours	Sick Leave Information Hourly Rate of Pay	Date Entered on NYBEAS	Effective Date

HBA Signature: **Date:**

Print Form