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

EMPLOYEE BENEFITS DIVISION

NYS Health Insurance Transaction Form

Graduate Student Employee Union - Student Employee Health Plan

PS-404G (2/07)

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 | 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 Child ☐ Yes ☐ No

10. ENTER REQUEST(S) BELOW

A. Request New Enrollment

☐ Individual ☐ Family (Complete D)

☐ Decline Coverage *(Process WAV/BEN transaction)*

☐ Voluntarily Cancel Coverage (Qualifying Event: _____)

B. Elect/Change Pre-Tax Status for Premium deduction

☐ Pre-Tax ☐ Post-Tax

If you chose Pre-Tax initial here to indicate that you have read the Pre-Tax Contribution memorandum. _____

C. ☐ **Change Coverage**

Date of Event: _____

☐ **Change to FAMILY** *(Complete D)*

- ☐ Marriage
- ☐ Domestic Partner acquired/first eligible
- ☐ First dependent child acquired
- ☐ Arrival of eligible dependent in United States
- ☐ 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
- ☐ Divorce
- ☐ Only dependent disqualified by age
- ☐ Termination of domestic partnership *(Attach Completed PS-425.4)*
- ☐ Other _____

D. 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								
☐ A ☐ D ☐ C								
☐ A ☐ D ☐ C								
☐ A ☐ D ☐ C								
☐ A ☐ D ☐ C								

AGENCY/EBD USE ONLY

Hire Date	Percentage Working	Agency Code	Neg. Unit	Action/Reason	Date of Event	Effective Date	
		2 8 _ _ 9	28				☐ Updated Medical ☐ Updated Dental ☐ Updated Vision

11. PREVIOUS COVERAGE INFORMATION

Complete this section if you are requesting new enrollment or a change to family coverage because you or your dependent's previous coverage was terminated (regardless of whether coverage was previously provided under NYSHIP or another health insurance plan) and you are requesting to have late enrollment of your benefits waived (attach proof: i.e. insurance bill or letter confirming former coverage and the end date of such coverage).

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

12. REQUEST FOR GSEU BENEFIT CARD (Student Employee Health Card) ONLY

☐ 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 NYS 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 COBRA Continuation Coverage rights for myself and/or my dependents. **I certify that the information I have supplied is true and correct.** I understand that my failure to provide required proof(s) within 30 days of the end of the initial or annual enrollment periods or within 30 days of a qualifying event 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 hereby ***authorize deduction from my salary*** 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)**