NEW YORK STATE OF OPPORTUNITY. **Department of Civil Service**

EMPLOYEE BENEFITS DIVISION
PA HEALTH INSURANCE TRANSACTION FORM

PS-503 (6/16)

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. Mailing Address (If PO Box, complete box 5)	City	State	Zip
5. Home Address (If different from mailing address)	City	State	Zip
6. Date of Birth	**7.** Telephone Numbers Home ( ) Work ( )	**8.** Work location and address	
9. Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated	Marital Status Date		

10. DEPENDENT INFORMATION

Must be provided to enroll in family coverage *(use additional sheets if necessary)*

Check One: A (Add), D (Delete), C (Change), M (Medicare) Date of Event: _____

↓	Last Name First Name MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security Number
☐ A ☐ D ☐ C ☐ M						
☐ A ☐ D ☐ C ☐ M						
☐ A ☐ D ☐ C ☐ M						
☐ A ☐ D ☐ C ☐ M						

11. MEDICARE INFORMATION

A. Covered under Medicare? ☐ Self Medicare ID Number: _____ ☐ Dependent Name: _____ Medicare ID Number: _____

B. Is enrollee or dependent reimbursed for Medicare by another entity? ☐ Self ☐ Dependent

12. NEW OR NEWLY ELIGIBLE EMPLOYEES: CHOOSE ONE OF THE FOLLOWING OPTIONS (A OR B)

C. Enroll in New York State Health Insurance Plan (NYSHIP) Coverage: Choose options 1 or 2

1. **Individual Enrollment**	☐ Empire Plan	☐ Excelsior Plan
2. **Family Enrollment** *(Complete box 10)*	☐ Empire Plan	☐ Excelsior Plan

D. Decline New York State Health Insurance Plan (NYSHIP) Coverage ☐

13. TO CHANGE OR CANCEL COVERAGE CHOOSE FROM THE BOXES BELOW

A. Change Coverage: Qualifying Event: _____ Date of Event: _____

☐ **Change to FAMILY** *(Complete box 10)*

- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Dependent returned to full-time student status
- ☐ 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: _____

B. Voluntarily Cancel Coverage: ☐ Qualifying Event: _____ Date of Event: _____

14.	**CORRECT SOCIAL SECURITY NUMBER**	
Correct Social Security Number	Incorrect SSN: _____	Correct SSN: _____

15.	**PREVIOUS COVERAGE INFORMATION**			
If you were previously covered under NYSHIP or another health insurance plan, please complete this section and attach proofs (i.e. insurance bill or letter stating former coverage).	Previous ID Number: _____		Date Coverage Terminated:	
	Enrollee's Name Under Which Previously Covered	Last Name	First Name	MI

16.	**RETIREMENT STATUS**	
Retirement/ Vestee Status	☐	I understand the requirements for continuing coverage as a retiree or vestee and wish to continue my coverage.
	☐	I understand the requirements for continuing coverage as a retiree or vestee and wish to defer my coverage.
Change Retiree Payment Status	Change to:	☐ Pension Deduction (Rate: _____ / _____) ☐ Direct Payment to Agency

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 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 Health Benefits Administrator**. If, after calling your 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 4:00 p.m.

AUTHORIZATION

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 the NYSHIP option I have selected. 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 or retirement allowance of the amount required, if any, for the coverage indicated above.**

Employee Signature (Required): _____ **Date:** _____

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	Date of 1st Eligibility	Percentage Working	Agency Code

Eligibility Lost Date	Retirement System	Retirement Tier	Registration #	Date Entered on NYBEAS	Effective Date

HBA Signature (Required): _____ **Date:** _____

ENROLLEE AND DEPENDENT INFORMATION

Boxes 1–9	Employee Information	You must complete boxes 1 – 9 with your personal information. Note: Use the Marital Status Date to show the date of marriage, separation or divorce when those marital statuses are selected.
Box 10	Dependent Information	Check the box to add (A) or delete (D) dependents, to change (C) dependent information or confirm a dependent is Medicare primary (M). Complete all dependent information including **date of birth**. Additional documentation may be required to add the dependent.
Box 11	Medicare Information	In row A, check the appropriate box if you or a dependent are covered under Medicare and then enter your Medicare ID and or the Medicare ID of your dependent and their name. In row B check the appropriate box(es) if you and/or your dependent covered under Medicare have your monthly fees reimbursed to you from an entity other than NYSHIP

NEW ENROLLEES

Boxes 12 (A-B)	New or Newly Eligible Employee Coverage Options	Complete appropriate sections. You may choose to enroll in or decline coverage. Check with your HBA for which plan or plans you are eligible to choose (Empire or Excelsior plan).
12.A.1	Individual Enrollment	Check Empire Plan or Excelsior Plan based on your option available.
12.A.2	Family Enrollment (must also complete dependent information in box 12)	Check Empire Plan or Excelsior Plan based on your option available.
12.B	Decline NYSHIP Coverage	Check box to decline coverage.

CHANGE IN COVERAGE OR VOLUNTARILY CANCEL COVERAGE

Box 13.A	Change Coverage	Check this box to change from Individual to Family or from Family to Individual coverage.
Box 13.B	Voluntarily Cancel Coverage	Choose this box when electing to voluntarily cancel your coverage.
Box 14	Correct Social Security Number	If your Social Security Number is incorrect in our system please put the incorrect number and correct numbers here so it can be fixed.

Box 15	Previous Coverage Information	If you are enrolling in coverage because your other coverage ended, complete all information in this box.
Box 16	Retirement/Vestee Status	**Retirement:** You must complete this section if you are to indicate your decision to continue or cancel/defer your health coverage as a retiree.
	Change Retiree Payment Status	Check the first box if you wish to adjust your pension deduction rate. Then, enter the new rate you would like deductions to be taken at. Check the second box if you are currently being billed monthly and would like to have your deductions taken directly out of your pension check. You will also need to submit a Pension Deduction Authorization Form along with this document. (Check first with your HBA regarding the availability of pension deduction)

AUTHORIZATION	You 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 with updating the enrollee's record on NYBEAS.

Action/Reason	Transaction that HBA will enter in NYBEAS.
Date of Event	Event date that 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 Date of 1st Eligibility	Original date of hire or rehire. (Only needed for new enrollment). The first day the enrollee is eligible for coverage.
Percentage Working	Enrollee's percentage on payroll.
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 the **Date** in the **Authorization Box** as **Date of Request**.

EXAMPLES OF DOCUMENTATION REQUIRED TO PROCESS YOUR TRANSACTION

Note: ALL employees and dependents must provide copies of his or her birth certificate

Spouse	**Domestic Partner**	**Children**
Copy of marriage certificate; for marriages dated more than one year prior, proof of current joint ownership/financial obligation	Completed PS-425 (Domestic Partner series) and required documentation	Completed PS-457 (Statement of Dependence) and required documentation, if applicable
For changes of coverage, copy of marriage certificate, divorce order or death certificate	For changes of coverage, PS-425.4 (Domestic Partner series) or copy of death certificate	Completed PS-451 (Statement of Disability) and required documentation, if applicable
Copy of Social Security Card	Copy of Social Security Card	