2024 NYSHIP Open Enrollment/Change Form
HR-BEN-060K

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

EMPLOYEE BENEFITS DIVISION
NYSHIP Health Insurance Transaction Form
for NYS & PE Employees
PS-404 (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: _____ Dependent Name: _____	Date: _____	
12. Is any of this information new? ☐ No ☐ Yes	Box Number(s): _____	Effective Date of Change: _____	

13. ENTER REQUEST(S) BELOW:

A. Pre-Tax Election

1. ☐ **Elect Pre-Tax Status** for Premium deduction

B. Elect a NYSHIP Coverage Option Below (You can ONLY choose ONE option between either 1 or 2)

1. Request Individual Enrollment	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	
2. Request Family Enrollment *(Must complete Box 14 below)*	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	
3. Medical Opt-out Program	You can only enroll in the Medical Opt-Out program during the annual Open Enrollment Period. Please complete the HR-BEN-036 Agreement to Decline (Opt-Out) Medical Coverage form OR visit My MTA Portal at **www.mymta.info** to easily opt out on-line.	

14. ENTER DEPENDENT INFORMATION:

MUST be provided when choosing to enroll or cancel NYSHIP family coverage *(use additional sheets if necessary)*

Check ONE: A (Add), D (Delete) or C (Change)
ONLY M (Medical) is applicable
Date of Event: _____

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

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15. ENTER ELECTION CHANGE(S) BELOW:

A. CHANGE Coverage: ☐ Medical *(10)* **Date of Event:** _____

☐ **Change to FAMILY Coverage** *(Must complete Box 14 on Page 1)* ☐ **Change to INDIVIDUAL Coverage**

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

- ☐ 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
- ☐ Only dependent graduated
- ☐ Other: _____

NOTE: If you are indicating a change in marital status to Divorced or Separated, please be sure to update the address information for the dependent in box 14 if applicable.

B. Voluntarily Decline or Cancel Coverage: ☐ Medical *(10)* **Qualifying Event:** _____

*(If currently enrolled in coverage & you would like to voluntarily **CANCEL** your coverage, please indicate the qualifying event above.)*

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 the Opt-out Attestation Form (if applicable) 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 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 USE ONLY

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

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

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NYSHIP Program Information Resources

To enroll in benefits or to change your current benefits, you will be required to submit proofs of eligibility for coverage or evidence of a qualifying event with the completed and signed NYSHIP *Health Insurance Transaction Form* PS-404. Learn more about these additional requirements in the following publications:

- ***General Information Book (GIB):*** Eligibility, enrollment, required forms and proofs of eligibility
- ***Planning for Option Transfer:*** The Pre-Tax Contribution Program (PTCP)
- ***Choices:*** Your plan options under NYSHIP (Empire Plan, NYSHIP HMO or the Opt-out Program) and the benefits included with each one

In many situations, you will also be required to complete, sign and submit additional forms and proofs. For detailed instructions on what will be required, please refer to your *GIB* and any additional forms and form instructions for requirements specific to your request.

Please return this completed form and all required supporting documentation to the MTA Business Service Center (BSC) via email at BSC-Benefits@mtabsc.org or via fax to 212-852-8700.

EMPLOYEE INFORMATION

Boxes 1 – 12	Employee Information	You must complete boxes 1 – 11 with your personal information. In Box 12, indicate if any of the information in Boxes 1 – 11 is new and needs to be undated on your NYSHIP record. Please also indicate which of the boxes contains updated information and a date of the change (if applicable). **Note:** Use the Marital Status Date to show the date of marriage, separation, or divorce when any of those marital statuses are selected.
Boxes 13 (A-B)	Elect Coverage	You can only select one (1) between Option 1 (Request Individual Enrollment) **OR** Option 2 (Request Family Enrollment) in Section B. You can **ONLY** enroll in the Medical Opt-Out Program during the annual Open Enrollment Period. Newly hired employees **MUST** wait until their respective Open Enrollment Period to enroll in the opt-out program. In order to opt-out, do **NOT** complete this form. Instead, during your Open Enrollment Period, you **MUST** complete the **HR-BEN-036 Agreement to Decline (Opt-Out) Medical Coverage Non-Represented & Eligible Represented Employees** form OR visit My MTA Portal at **www.mymta.info** to easily opt out on-line.

ELECT COVERAGE

Note: If you choose a NYSHIP HMO, the HMO may require you to complete an additional enrollment form.

13.A.1 13.A.2	Pre-Tax Contribution Program (PTCP) Status	The PTCP applies to all NYS groups and select Participating Employers (PE).
13.B.1	Request Individual Enrollment	Check box to enroll in Individual Coverage.
13.B.2	Request Family Enrollment	Check box to enroll in Family Coverage.
13.B.3	Medical Opt-out Program	To participate in Medical Opt-Out, do **NOT** complete this form. You **MUST** visit **My MTA Portal** to opt out online OR complete HR-BEN-036 Opt-Out form during your Open Enrollment Period.

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DEPENDENT INFORMATION

Box 14	Dependent Information	Check the box to add or delete a dependent or to change a dependent's information. Check the Medical box as the coverage being changed. Complete all dependent information and provide the dependent's Social Security Number. Additional documentation is required to add dependent(s).

CHANGE COVERAGE OR VOLUNTARILY DECLINE/CANCEL COVERAGE

Box 15.A	Change Coverage	Check this box to change from Individual to Family or from Family to Individual coverage. If you are enrolled in PTCP, you may only change coverage from Family to Individual during the applicable annual open enrollment period or within 30 days of a PTCP qualifying event (check the qualifying event and enter the Date of Event). Check the Medical box as the coverage being changed. In the event that you are indicating a change in your marital status to divorced or separated, please update the dependent's new address, if applicable, in the Dependent Information section (Box 14).
Box 15.B	Voluntarily Decline or Cancel Coverage	You are entitled to voluntarily ***Decline*** coverage if you are a newly hired employee *OR* promoted into an eligible role/title. Due to a qualifying life event *OR* during your respective open enrollment period, you are eligible to voluntarily ***Cancel*** your current enrollment/coverage.

AUTHORIZATION	You must SIGN and DATE this form.

REQUIRED DOCUMENTATION

To Add Dependents and To Maintain Dependent Child(ren) Coverage

I. For Spouse

A copy of Marriage Certificate, Birth Certificate, Social Security card, **AND,** if your date of marriage is more than one year old,

- *Your most recent Tax Return* – Federal or State (including Puerto Rico Returns)
  1. Your most recent tax return showing "married filing jointly" **OR** "married filing separately." Your spouse's name must appear on the tax form on the line provided after the "married filing separately" status (or vice versa).
  2. Only submit page 1 of the return. This could include the 1040 form, e-File Confirmation Page, Tax Preparer's Summary, or Federal Return Recap.
  3. Eliminate all financial information, **OR**

Proof of Joint Ownership

Both the enrollee and spouse's name must be listed on the documentation of joint ownership and be dated within the past 90 days. Examples include a copy of:

- Homeowners/Renters Insurance Policy
- Credit Card Statement
- Loan Obligation
- Bank Account Statement
- Mortgage Statement
- Property Tax Document
- Rental/Lease Agreement
- Utility/phone/internet/cable bills
- Pension/life insurance/will designating spouse as beneficiary

II. For Children

For a Natural-Born Child, a copy of:

- Birth Certificate showing employee's name
- Social Security Card

For a Stepchild or Legally Adopted Child, a copy of:

- Birth Certificate or Adoption Certificate
- Social Security Card

III. Dependent Children to age 26

may be eligible for medical benefits under an employee's family coverage.

IV. Dependent Children Coverage ages 19 and 25

Dependent children age 19 to 25, or, if applicable, age as specified in your Collective Bargaining Agreement (CBA) may be eligible for dental and vision care benefits. To enroll or maintain enrollment for your dependent(s) over age 19, and up to age 25 (or per CBA if applicable), for MetLife dental and EyeMed vision benefits coverage, you must provide verifiable proof of your child's full-time student status for each semester.

You may provide proof of full-time status in the form of any of the following: a letter, statement, or documentation from the Bursar or Registrar's office, a printout from the Clearinghouse, or a paid receipt that includes the number of classes/credits.

V. When Dependents Are No Longer Eligible

For a dependent to be eligible for COBRA coverage continuation, your dependent must enroll for COBRA coverage within 60 days of losing coverage (the qualifying event date).

- You must inform the MTA BSC when your dependent is no longer a full-time student. The BSC will update the dependent's status. COBRA Dental and Vision coverage is administered by the WEX Health, Inc.
- WEX Health, Inc. will send you your COBRa notification package.