Department of Civil Service
Albany, NY 12239

Instructions for NYSHIP Health Insurance Transaction Form
PS-404 (12/2021)

NYSHIP Program Information Resources

To enroll in benefits or to change your current benefits, you will most likely be required to submit proofs of eligibility for coverage or evidence of a qualifying event with the completed and signed *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.

Boxes 1 – 11	Employee Information	You must complete boxes 1 – 11 with your personal information. **Note:** Use the Marital Status Date to show the date of marriage, separation or divorce when any of those marital statuses are selected.
Boxes 12 (A-B)	Elect or Change Coverage	Complete the appropriate sections. You can only select one (1) option between available options 1, 2, or 3 in Section B. To participate in the Medical Opt-Out Program, please do **NOT** complete or submit this form. Instead, you **must** complete the **HR-BEN-036 Agreement to Decline (Opt-Out) Medical Coverage Non-Represented and Eligible Represented Employees** form or visit My MTA Portal at www.mymta.info to quickly and easily opt-out online.

12.A.1 12.A.2	Pre-Tax Contribution Program (PTCP) Status	The PTCP applies to all NYS groups and select Participating Employers (PE).
12.B.1	Request Individual Enrollment	Check box to enroll in Individual coverage.
12.B.2	Request Family Enrollment	Check box to enroll in Family coverage.
12.B.3	Medical Opt-Out Program	To participate in the Medical Opt-Out Program, do **NOT** complete this form. Instead, you **MUST** visit My MTA Portal to opt-out online OR complete the HR-BEN-036 Opt-Out form.

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Box 13.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 13.B	Voluntarily Decline or Cancel Coverage	You are entitled to voluntarily decline coverage if newly hired or promoted into an eligible role/title. As a result of a qualifying life event OR during your appropriate open enrollment period, you are able to voluntarily cancel your coverage.

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).

AUTHORIZATION	You must SIGN and DATE this form.

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EMPLOYEE BENEFITS DIVISION
NYSHIP Health Insurance Transaction Form
for Participating Employer (PE) Employees

PS-404 (12/2021)

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. 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: ☐ Yes ☐ No	Spouse/Domestic Partner: ☐ Yes ☐ No	Child: ☐ Yes ☐ No	

12. ENTER REQUEST(S) BELOW

A. Pre-Tax Election

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

B. Elect or Change to a NYSHIP Coverage Option Below (You can only choose one option between either 1, 2, or 3)

1. Request Individual Enrollment	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ____ Name ____________
2. Request Family Enrollment *(Must complete Box 14 on Page 2)*	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ____ Name ____________
3. Medical Opt-Out Program *(Only for those enrolled in the Pilot Program)*	If interested in participating in the Medical Opt-Out Program, do NOT complete this form. You must instead 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 online**.

13. ENTER REQUEST(S) BELOW

A. Elect or Change Coverage: ☐ Medical *(10)* **Date of Event:**____________

☐ **Elect/Change to FAMILY Coverage** *(Must complete Box 14 on Page 2)*
- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Dependent returned to full-time student status
- ☐ Other: ____________________

☐ **Elect/Change to INDIVIDUAL Coverage**
- ☐ Divorce
- ☐ Termination of Domestic Partnership
- ☐ Only dependent ineligible due to age
- ☐ I voluntarily cancel coverage for my dependents
- ☐ Only dependent died
- ☐ Only dependent married
- ☐ 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 & would like to voluntarily cancel your coverage, please indicate the qualifying event above.)

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14. DEPENDENT INFORMATION

MUST be provided when choosing to enroll or opt-out of 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: __________

Check One	Coverage	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						

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:**