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

EMPLOYEE BENEFITS DIVISION

NYSHIP Health Insurance Transaction Form
for Participating Agencies (PAs)

PS-503 (6/2024)

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: _____ Is the enrollee reimbursed for Medicare by another entity? ☐ No ☐ Yes		
☐ Dependent Medicare ID Number: _____ Date: _____ Dependent Name: _____ Is the dependent reimbursed for Medicare by another entity? ☐ No ☐ Yes		
12. Is any of this information new? ☐ No ☐ Yes Box Number(s): _____		Effective Date of Change: _____

13. ELECT OR DECLINE COVERAGE

New or Newly Eligible Employees: Choose one of the following options (A or B)

A. 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 14)*	☐ Empire Plan	☐ Excelsior Plan

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

14. DEPENDENT INFORMATION

Must be provided to enroll in family coverage *(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	Gender	Address *(if different)*	Social Security Number
☐ A ☐ D ☐ C				☐ F ☐ M ☐ X		
☐ A ☐ D ☐ C				☐ F ☐ M ☐ X		
☐ A ☐ D ☐ C				☐ F ☐ M ☐ X		
☐ A ☐ D ☐ C				☐ F ☐ M ☐ X		

15. CHANGE OR CANCEL EXISTING COVERAGE

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

☐ **Change to FAMILY** *(Complete box 14 on page 1)*

- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Other: _____

☐ **Change to INDIVIDUAL**

- ☐ Divorce
- ☐ Termination of Domestic Partnership *(Attach completed PS-425.4)*
- ☐ I voluntarily cancel coverage for my dependents
- ☐ Only dependent died
- ☐ Other: _____

B. Voluntarily Cancel Coverage: ☐ Event/Reason: _____ Date of Event: _____

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**.

17. DONATE LIFE REGISTRY ELECTION

You must fill out the following section:

Would you like to be added to the Donate Life Registry? ☐ Yes ☐ Skip this question

Check box for 'yes' or 'skip this question.'

This question must be answered each time the form is filled out.

By indicating yes in response to the question asking if you would like to be added to the Donate Life Registry, you are certifying that you are 16 years of age or older, consenting to donate your organs and tissues for the purposes of transplantation and research in the event of your death and authorizing NYSHIP to share your name and identifying information with the Registry.

ID Number on New York State Driver License, Learner Permit, or Non-Driver ID Card

_____

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. 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

Pursuant to the following Sections of NYS Retirement and Social Security Law: 110-a; 110-b; 110-c; 110-d; 410-a; 410-b or 410-c, I hereby authorize the NYS Department of Civil Service (DCS) to deduct an amount from my monthly retirement allowance from the New York State and Local Retirement Systems (NYSLRS) to cover any deductions for insurance premiums payable on behalf of DCS. Authorization is given to make any future adjustment deductions and/or changes DCS certifies to NYSLRS as necessary in the amount of such insurance premiums. I understand that all requests to begin, modify, or revoke deductions must be submitted to my current/former agency and provided to DCS. This authorization shall remain in effect until revoked by me by written notice or until otherwise revoked pursuant to law.

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

Change Retiree Payment Status to: ☐ Pension Deduction (Rate: _____ / _____) ☐ Direct Payment to Agency

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

EMPLOYEE INFORMATION

Boxes 1–10	Employee Information	You must complete boxes 1 – 10 with your personal information. Note: Use the Marital Status Date to show the date of marriage, separation, divorce or death of a spouse when those marital statuses are selected.
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 are covered under Medicare and have your monthly fees reimbursed to you from an entity other than NYSHIP or your NYSHIP Participating Agency.
Box 12	Changes in Employee 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).

ELECT OR DECLINE COVERAGE

Boxes 13 (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).
13.A.1	Individual Enrollment	Check Empire Plan or Excelsior Plan based on your option available.
13.A.2	Family Enrollment (must also complete dependent information in box 14)	Check Empire Plan or Excelsior Plan based on your option available.
13.B	Decline NYSHIP Coverage	Check box to decline coverage if you do not wish to enroll in NYSHP coverage.

DEPENDENT INFORMATION

Box 14	Dependent Information	Check the box to add (A) dependents, delete (D) dependents, or to change (C) dependent information. Complete all dependent information including **date of birth**. Additional documentation may be required to add the dependent.

CHANGE OR CANCEL EXISTING COVERAGE

Box 15.A	Change Coverage	Check this box to change from Individual to Family or from Family to Individual coverage. Restrictions may apply if you are enrolled in pre-tax – see your HBA for more details
Box 15.B	Voluntarily Cancel Coverage	Choose this box when electing to voluntarily cancel your coverage.

RETIREMENT STATUS

Box 16	Retirement / Vestee Status	You must complete this section if you are to indicate your decision to continue or cancel/defer your health coverage as a retiree or vestee.

DONATE LIFE REGISTRY ELECTION

Box 17	Donate Life Registry Election	**Donate Life Registry:** Check box for 'yes' or 'skip this question.' **This question must be answered each time the form is filled out.** If you check the box marked 'Yes', you are indicating your consent to enroll in the Donate Life Registry. You understand that by enrolling in the Registry, you are giving legal consent to the donation of your organs, tissues and eyes in the event of your death. You authorize access to the information as needed for the administration of the Registry and to federally regulated organ procurement organizations, New York State licensed tissue and eye banks, and entities formally approved by the NYS Commissioner of Health at or near the time of your death. **NYS DMV ID:** If you check the 'Yes' box, it is recommended that you provide an ID number from your New York State Driver License, Learner Permit, or Non-Driver ID card. If you check the 'skip this question' box, skip this section.

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

Spouse	Domestic Partner	Child
1. Copy of Birth Certificate	1. Copy of Birth Certificate	1. Copy of Birth Certificate
2. Social Security Number (copy of Medicare Card if applicable)	2. Social Security Number (copy of Medicare Card if applicable)	3. Social Security Number (copy of Medicare Card if applicable)
3. Copy of Marriage Certificate (if the marriage took place more than one year ago — see #4 below)	4. Completed PS-425 Domestic Partner application and acceptable proof as defined in the application.	2. For children over 26, approved PS-451 Statement of Disability Form.
4. For marriages that took place more than one year ago, proof of current joint ownership/joint financial obligation is required (i.e.: prior year's tax return). If tax document is not provided, a current bank statement, mortgage statement or homeowner's policy may be provided.		3. For Relationship of 'Other' Child, a completed PS-457 Statement of Dependence is required along with acceptable proof as defined in the PS-457.