



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 <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated							Marital Status Date	
11. Covered under Medicare?		<input type="checkbox"/> Self Medicare ID Number: _____ Date: _____						
		<input type="checkbox"/> Dependent Medicare ID Number: _____ Date: _____ Dependent Name: _____						
12. Is any of this information new? <input type="checkbox"/> No <input type="checkbox"/> Yes Box Number(s): _____ Effective Date of Change: _____								

13. ENTER REQUEST(S) BELOW:		
A. Pre-Tax Election		
1. <input type="checkbox"/> 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) <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code <input type="text"/> Name _____	
2. Request Family Enrollment <small>(Must complete Box 14 below)</small>	Medical (10) (Select Empire Plan or HMO) <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code <input type="text"/> 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)					Date of Event: _____				
ONLY M (Medical) is applicable									
		Last Name	First Name	MI	Relationship	Date of Birth	Gender	Address (if different)	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M						<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X		
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M						<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X		
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M						<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X		

2024 NYSHIP Open Enrollment/Change Form

HR-BEN-060K

Department of Civil Service
Albany, NY 12239

NYSHIP Health Insurance Transaction Form
PS-404 (1/2023)

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

- 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: _____

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		Date Entered on NYBEAS	Effective Date
		# Hours	Hourly Rate of Pay		

HBA Signature (Required): _____

Date: _____

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Instructions for NYSHIP Health Insurance Transaction Form
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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 updated 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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Albany, NY 12239Instructions for NYSHIP Health Insurance Transaction Form
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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).
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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 <u>Decline</u> coverage if you are a newly hired employee <u>OR</u> promoted into an eligible role/title. Due to a qualifying life event <u>OR</u> during your respective open enrollment period, you are eligible to voluntarily <u>Cancel</u> your current enrollment/coverage.

AUTHORIZATION	You must SIGN and DATE this form.
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