

10 Cont'd **ENTER REQUEST(S) BELOW**

H. Change Retiree Payment status Change to: pension deduction (Rate ____/____) direct payment to agency (APAY)
I. Correct Social Security Number Incorrect SSN:

11 **PREVIOUS COVERAGE INFORMATION**

If you were previously covered under NYSHIP or another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.	Previous ID Number:	Date Coverage Terminated:		
	Enrollee's Name Under Which Previously Covered	Last	First	Middle Initial

12 **LEAVE WITHOUT PAY AND RETIREMENT STATUS**

LEAVE WITHOUT PAY I wish to continue coverage while I am on authorized leave. I understand that I will be billed for this coverage.
 I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll.

RETIREMENT/ VESTEE STATUS I understand the requirements for continuing medical insurance coverage as a **retiree** and wish to continue my coverage.
 I understand the requirements for continuing medical insurance coverage as a **vestee** and wish to continue my coverage.

13 **REQUEST FOR EMPIRE PLAN CARD**

DUPLICATE CARD (Previously issued card remains valid.) **FOR** ENROLLEE
 REPLACEMENT CARD (Previously issued card(s), lost or stolen, become invalid.) ENROLLEE AND ALL DEPENDENTS
 INDIVIDUAL DEPENDENT Name _____

Personal Privacy Protection Law Notification

This information you provide on this application is being requested pursuant to Section 163 of the New York State Civil Service Law for the purpose of enabling the NYS 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 your Personnel Office and by the Employee Benefits Division, NYS Department of Civil Service, The State Campus, Albany, NY 12239. For further information relating *only* to the Personal Protection Law, call (518) 457-9375. For information related to the Health Insurance Program, **contact your Agency Health Benefits Administrator**. If, after calling your Agency 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 3:00 p.m.

AUTHORIZATION

I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving agency service (vest, retirement, etc.). **I certify that the information I have supplied is true and correct.** 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 misstatement of fact or conceals any pertinent information, commits a crime which is subject to a \$5,000 penalty *and* the stated value of the claim for *each* violation. I hereby **authorize deduction from my salary or retirement allowance** of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

Employee's Signature (Required) _____ **Signature Date (Required)** _____

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	First Eligibility Date	Agency Code	Date Eligibility Lost	Retirement System
Retirement Tier	Registration #	Pension Deductions		Date Entered on NYBEAS	Effective Date	
		Yes _____	No _____			

HBA Signature: _____ **Date:** _____