University at Buffalo
Human Resources
Division of Finance and Administration

Opt-Out Program 2019
Enrollment Package

Name _____ Person Number _____

Email _____ Phone Number _____

DEADLINE

All forms are due by close of business **Jaunary 18, 2019** Incomplete forms or applications missing required documentation **cannot be processed**. Return your enrollment package to Human Resources, 120 Crofts Hall, North Campus.

ELIGIBILITY

In order to be eligible to enroll in the **Opt-Out program for 2019**, you must meet one of the following criteria. If you are unable to check one of the boxes below, you may not be eligible to enroll.

☐ I am currently enrolled in the Opt-out Program and plan to continue my enrollment.

☐ I am currently enrolled in a NYSHIP health insurance option and enrolled prior to April 1, 2018. I have obtained other employer sponsored health insurance effective on or prior to January 1, 2019 that qualifies me (see enclosed PS-409 form for qualifying coverage) to opt-out of my NYSHIP plan.

☐ I am currently enrolled in a NYSHIP health insurance option and enrolled after April 1, 2018 when I was first eligible to enroll. I have obtained other employer sponsored health insurance effective on or prior to January 1, 2019 that qualifies me (see enclosed PS-409 form for qualifying coverage) to opt-out of my NYSHIP plan.

INSTRUCTIONS

Choose one option below and follow the checklist to complete all steps for enrolling in the Opt-out Program. All forms in this package must be completed accurately in order for your request to be processed.

I am currently enrolled in the Opt-out Program and would like to reenroll.

☐ **I am opting out of individual coverage.**

- ☐ Complete the enclosed PS-404 form.
  - ✓ Page 1: Complete parts 1 – 10.
  - ✓ Page 2: Choose Individual Opt-out in section 14.
  - ✓ Page 2: Sign and date your form in the authorization section.
- ☐ Complete the enclosed PS-409 form.
  - ✓ Complete all sections.

☐ **I am opting out of family coverage.**

- ☐ Complete the enclosed PS-404 form.
  - ✓ Page 1: Complete parts 1 – 10.
  - ✓ Page 2: Choose Family Opt-out in section 14.
  - ✓ Page 2: Sign and date your form in the authorization section.
- ☐ Complete the enclosed PS-409 form.
  - ✓ Complete all sections.

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I am not currently enrolled in the Opt-out Program and would like to enroll.

☐ **I am opting out of individual coverage.**

- ☐ Complete the enclosed PS-404 form.
  - ✓ Page 1: Complete parts 1 – 10.
  - ✓ Page 2: Choose Individual Opt-out in section 14.
  - ✓ Page 2: Sign and date your form in the authorization section.
- ☐ Complete the enclosed PS-409 form.
  - ✓ Complete all sections.
- ☐ Enclose a copy of your other health insurance ID card.

☐ **I am opting out of family coverage.**

- ☐ Complete the enclosed PS-404 form.
  - ✓ Page 1: Complete parts 1 – 10.
  - ✓ Page 2: Enter the dependent information in section 13.
  - ✓ Page 2: Choose Family Opt-out in section 14.
  - ✓ Page 2: Sign and date your form in the authorization section.
- ☐ Complete the enclosed PS-409 form.
  - ✓ Complete all sections.
- ☐ Enclose a copy of your other health insurance ID card.

PLEASE WRITE SOCIAL SECURTY NUMBERS LEGIBLY FOR ALL DEPENDENTS

SUBMITTING YOUR FORMS

Via fax:	716-645-3830
By campus mail or in-person*:	UB HR Benefits 120 Crofts Hall North Campus

CONFIRMATION OF RECEIPT

Due to heavy enrollment volume, we are unable to meet with employees individually to check their paperwork for accuracy:

Each Monday we will send an email notice to all those employees whose paperwork we received the preceding week

We will confirm in this email if your paperwork is **correct or incorrect**

If **correct**, no further action is required from you

If **incorrect**, please follow the email instructions to correct your paperwork

You will receive **only one notice** that your paperwork is incorrect

It is your responsibility to make sure your completed paperwork is received in UB HR Benefits by the deadline date

If you do not respond by the deadline date to correct your paperwork then it will not be processed

Please contact UB HR Benefits at 716-645-7777 or via email to ub-hr-benefits@buffalo.edu

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

EMPLOYEE BENEFITS DIVISION
HEALTH INSURANCE TRANSACTION FORM
FOR NYS & PE EMPLOYEES PS-404 (9/17)

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. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated | Marital Status Date

10. Covered under Medicare? Self: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No Child: ☐ Yes ☐ No

11. ELECT OR DECLINE COVERAGE

A. Choose a Pre-Tax election (Only eligible for Pre-Tax deductions if newly eligible or if requested during the PTCP election period, Nov 1-30)

1. ☐ **Elect Pre-Tax Status** for Premium deduction **2.** ☐ **Elect After-Tax Status** for Premium deduction

B. Select a NYSHIP Coverage Option (Choose option 1, 2, 3 or 4)

1. Individual Enrollment	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	☐ Dental *(11)*	☐ Vision *(14)*
2. Family Enrollment *(Complete box 13 on page 2)*	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	☐ Dental *(11)*	☐ Vision *(14)*
3. Opt-out Program *(NYS Medical only)*	☐ Individual Opt-out ☐ Family Opt-out (Complete Box 13) If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.	☐ Dental *(11)*	☐ Vision *(14)*
4. Decline Coverage	☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)*		

12. CHANGE OR CANCEL EXISTING COVERAGE

A. Change Coverage: ☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* **Date of Event:** _____

☐ **Change to FAMILY** *(Complete box 13)*

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

☐ **Change to INDIVIDUAL**

- ☐ 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 married *(Dental and Vision only)*
- ☐ Only dependent graduated *(Dental and Vision only)*
- ☐ 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 13 if applicable.

B. Voluntarily Cancel Coverage: ☐ Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* Qualifying Event: _____

NOTE: If you are enrolled in the Pre-Tax Contribution Program, you may make changes during the Annual Option Transfer Period or when experiencing a qualifying event.

13. 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)
Check all that apply: M (Medical), D (Dental), and V (Vision)

Date of Event: _____

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

14. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW

Change NYSHIP Option	Change to: ☐ Empire Plan ☐ HMO Code ☐ HMO Name: _____	
Elect Opt-out *(NYS Medical only)*	☐ Individual Opt-out ☐ Family Opt-out	If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.
Change Pre-Tax Status	Change to: ☐ Pre-Tax ☐ After-Tax	Submit during the Pre-Tax Contribution Selection Period (November 1-30)

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 of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 473-2624. 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. Eastern time.

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:**

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE BENEFITS DIVISION

Opt-out Program Attestation Form

PS-409 (11/17)

EMPLOYEE INFORMATION

Last Name	First Name	M.I.

Date of Birth	NYS Employee ID (from payroll check) N __ __ __ __ __ __ __ __	Agency Name

Home Address	City	State	Zip

Work Address	City	State	Zip

Telephone Numbers Home Work

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Marital Status Date

NYSHIP HEALTH BENEFITS OPT-OUT ELECTION

If you are eligible to Opt-out, please **check one:**

☐ I am electing to **Opt-out of Individual coverage** in exchange for a $1,000 taxable payment ($38.47 over 26 biweekly paychecks).

☐ I am electing to **Opt-out of Family coverage** in exchange for a $3,000 taxable payment ($115.39 over 26 biweekly paychecks).

For questions regarding eligibility for the Opt-out Program, see your Health Benefits Administrator (HBA) or the publications *Planning for Option Transfer* and your *General Information Book* available at NYSHIP Online www.cs.ny.gov/employee-benefits.

OTHER EMPLOYER-SPONSORED GROUP HEALTH INSURANCE INFORMATION

You must have other employer-sponsored group health insurance to be eligible for the Opt-out Program.
Other employer-sponsored group health coverage **cannot be**:

- The result of your or your spouse's, domestic partner's or parent's employment relationship with NYS, or
- The result of your own employment with a NYSHIP Participating Agency (PA) or Participating Employer (PE).

I have other employer-sponsored group health insurance coverage… (please check one)

☐ as a dependent on another person's policy ☐ through my own employment.

My other employer-sponsored group health insurance coverage is… (please check one)

☐ NYSHIP coverage ☐ Not NYSHIP coverage

Other employer-sponsored group health insurance policy holder information:

Name of Policy Holder _____

Policy Holder's Employer _____

Employer's address _____

Other employer-sponsored group health insurance plan information:

Plan Name _____ Effective Date of Coverage _____

Plan Address _____

(You **must** provide either a copy of your health insurance card or a letter from your employer or other health insurance provider confirming current coverage.)

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE BENEFITS DIVISION

Opt-out Program Attestation Form

PS-409 (11/17)

ATTESTATION

I have read the Opt-out Program materials and instructions and I attest to the following:

- I meet the qualifications to elect the Health Insurance Opt-out Program.
- I understand that I must promptly report changes that may impact my eligibility or payment amount (e.g., loss of other employer-sponsored coverage, divorce, death, last dependent loses eligibility for NYSHIP coverage) If I fail to do so, I am responsible for any Opt-out Program payments made to me in error. I understand that Opt-out Program payments made to me in error may be recovered as special deductions of up to $200 from my biweekly paycheck.
- I understand that I may choose to opt out of Family coverage only if I have NYSHIP eligible dependents and I am not enrolled in NYSHIP as a dependent or enrollee through NYS or another NYSHIP employer, and that I must provide proof of my dependent's eligibility when enrolling each year.
- I understand that this election is for only one plan year even when first time enrollment is at the end of the plan year. I must submit the PS-404 and PS-409 again during the next Option Transfer Period if I am eligible and choose to continue in the Opt-out Program.

Employee's Signature (Required) _____ Date_____

The information you provide on this application is requested in accordance with Section 163 of 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 of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. 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.

This form is <u>invalid</u> if it is not signed and submitted along with a completed PS-404.

AGENCY USE ONLY

Date Received	Date Processed	HBA Initials