

DEADLINE

All forms are due by close of business **December 31, 2019**. Paperwork received after this date **will not be processed**. Changes will take effect December 26, 2019 unless otherwise specified on this form.

INSTRUCTIONS

1. Find the appropriate checklist(s) for the change(s) you want to make
 - a. Use the form(s) included in this enrollment package
2. Follow the instructions
3. **Please type or write legibly**
4. Print your form(s)
5. Sign the form(s)
6. Please keep a copy for your records
7. **Send your enrollment form(s) only** to UB HR Benefits – **we do not need the instructions**

SUBMITTING YOUR FORMS

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

If you drop-off your forms **in-person***, leave them with the receptionist in room 120 Crofts. You will receive a **Confirmation of Receipt** (see below) from UB HR Benefits **the following Monday**

CONFIRMATION OF RECEIPT

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

- The following 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**

QUESTIONS

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

CHANGING HEALTH INSURANCE CARRIERS

Complete the PS-404:

Page 1: complete 1-10

Page 2: in box 14 'ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW'

- Change NYSHIP Option
- If changing to Empire check the box next to Empire Plan
- If changing to an HMO check the box next to HMO write in code and name
- Sign and date your form in the authorization section

CANCELLING COVERAGE

Complete the PS-404:

Page 1: complete 1-10

Page 1: In box 12 'CHANGE OR CANCEL EXISTING COVERAGE'

- In 12 B Voluntarily Cancel Coverage check the box for Medical (10)

Page 2: Sign and date your form in the authorization section

REMOVING A DEPENDENT

Complete the PS-404:

Page 1: complete 1-10

Page 2: Go to box 13 'DEPENDENT INFORMATION'

- Check box D (delete)
- Check box M (medical)
- Add the information for the dependent you are removing (one line per dependent)
- Sign and date your form in the authorization section

CHANGING TO INDIVIDUAL COVERAGE

Complete the PS-404:

Page 1: complete 1-10

Page 1: Go to box 12 'CHANGE OR CANCEL EXISTING COVERAGE'

- Check the following boxes:
 - M (medical)
 - Change to Individual
 - I voluntarily cancel coverage for all my dependents

Page 2: Sign and date your form in the authorization section

CHANGING PRE-TAX STATUS (PTCP)

Complete the PS-404:

Page 1: complete 1-10

Page 2: in box 14 'ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW'

- Change Pre-Tax Status
- Check the box next to either Pre-Tax or After-Tax

Page 2: Sign and date your form in the authorization section

ENROLLING IN THE OPT-OUT PROGRAM

You are eligible to participate *if*:

- ✓ You are currently enrolled in a NYSHIP option prior to April 1, 2019
 - **Or** enrolled after April 1, 2019 when first eligible to enroll
- ✓ You have obtained other ***employer sponsored*** health insurance effective on or prior to January 1, 2020

Your opt-out choice must correspond to your current NYSHIP enrollment option:

- ✓ If you are enrolled in individual coverage you may only opt-out of individual coverage
- ✓ If you are enrolled in family coverage you may only opt-out of family coverage

Complete the PS-404:

Page 1: complete 1-10

Page 2: in box 14 'ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW'

- Elect Opt-out
- Check the box next to either Individual Opt-out or Family Opt-out
- Sign and date your form in the authorization section

Complete the PS-409:

- Page 1: Complete all sections
- Enclose a copy of one of the following that confirms current coverage
 - Copy of your other health insurance id card **or**
 - Letter from your employer confirming current coverage **or**
 - Letter from your health insurance provider confirming current coverage
- Page 2: Sign and date your form in the Attestation section

Submit both the PS404 and PS409 to enroll in the Opt-out Program



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 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 10. Covered under Medicare?

11. ELECT OR DECLINE COVERAGE

A. Choose a Pre-Tax election 1. Elect Pre-Tax Status 2. Elect After-Tax Status B. Select a NYSHIP Coverage Option 1. Individual Enrollment 2. Family Enrollment 3. Opt-out Program 4. Decline Coverage

12. CHANGE OR CANCEL EXISTING COVERAGE

A. Change Coverage: 1. Marriage 2. Divorce 3. Domestic Partner 4. Termination of Domestic Partnership 5. Newborn 6. Only dependent ineligible due to age 7. Request coverage for dependents not previously covered 8. I voluntarily cancel coverage for my dependents 9. Previous coverage terminated 10. Only dependent died 11. Dependent returned to full-time student status 12. Only dependent married 13. Other: 14. Other: B. Voluntarily Cancel Coverage: 1. Medical 2. Dental 3. Vision

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)						Date of Event: _____			
Check all that apply: M (Medical), D (Dental), and V (Vision)									
↓	↓	Last Name	First Name	MI	Relationship	Date of Birth	Sex	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"/> D <input type="checkbox"/> V								
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V								
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V								
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V								

14. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW		
Change NYSHIP Option	Change to: <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code <input style="width: 30px; border: 1px solid black;" type="text"/>	HMO Name: _____
Elect Opt-out <i>(NYS Medical only)</i>	<input type="checkbox"/> Individual Opt-out <input type="checkbox"/> Family Opt-out	If choosing Opt-out, you must also complete the PS-409 Opt-out Attestation Form.
Change Pre-Tax Status	Change to: <input type="checkbox"/> Pre-Tax <input type="checkbox"/> After-Tax	Submit during the Pre-Tax Contribution Program Election Period

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	
<p>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 <i>Summary of Benefits and Coverage</i> 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.</p>	
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: _____	



You only need to complete the following form, PS409, if you are enrolling in the Opt-out program

If you are enrolling in Opt-out you must submit both the PS404 and PS409, please follow the instructions on page 3



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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 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.)



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.

Employee's Signature (Required) _____ Date _____

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

AGENCY USE ONLY

Date Received	Date Processed	HBA Initials