University at Buffalo
Human Resources

Option Transfer Enrollment Package

DEADLINE

All forms are due by close of business December 31, 2021. Paperwork received after this date will not be processed. Changes will take effect January 6, 2022, unless otherwise specified on this form.

INSTRUCTIONS

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

SUBMITTING YOUR FORM(S)

DO NOT SUBMIT VIA EMAIL

1. Save your documentation as a **single PDF file**
2. Rename your file to include: Your Last Name_Your First Name_Your Person Number **(ex. Smith_John_22222222)**
3. Upload your file to the Option Transfer Secure UB Box Folder
   - ✓ You will receive an on-screen confirmation that your upload was successful

CONFIRMATION OF RECIEPT

Due to heavy enrollment volume, we will send a confirmation of receipt the Monday following the date you uploaded your paperwork. This message will be sent to all those employees whose paperwork we received the preceding week via **your UB email address**.

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:
  - o You will receive only one notice that your paperwork is incorrect
  - o It is your responsibility to make sure your completed paperwork is received in UB HR Benefits by the deadline date
  - o **If you do not respond by December 31, 2021, close of business to correct your paperwork, it will not be processed**

QUESTIONS

Please contact UB HR Benefits at 716-645-7777 or via email to ub-hr-benefits@buffalo.edu. **Due to heavy volume, please allow 2 to 3 business days for a response.**

CHANGING HEALTH INSURANCE CARRIERS

Complete the PS-404 or complete this change using MYNYSHIP:
Page 1: Complete 1 – 11
Page 2: In box 15 'ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW'

- ✓ Change NYSHIP Option
  - If changing to the Empire Plan, check the box next to Empire Plan
  - If changing to an HMO, check the box next to HMO write in code and/or name

Page 2: Sign and date in the 'AUTHORIZATION' section

CANCELLING COVERAGE

Complete the PS-404:
Page 1: Complete 1 – 11
Page 2: In box 13 'CHANGE OR CANCEL EXISTING COVERAGE'

- ✓ In 13 B 'Voluntarily Cancel Coverage', check the box for 'Medical (10)'

Page 2: Sign and date in the 'AUTHORIZATION' section

REMOVING A DEPENDENT

Complete the PS-404:
Page 1: Complete 1 – 11
Page 2: In box 14 'DEPENDENT INFORMATION'

- ✓ Check box 'D' (delete)
- ✓ Check box 'M' (medical)
- ✓ Add the information for the dependent(s) you are removing (one line per dependent)

Page 2: Sign and date in the 'AUTHORIZATION' section

CHANGING TO INDIVIDUAL COVERAGE

Complete the PS-404:
Page 1: Complete 1 – 11
Page 2: In box 13 'CHANGE OR CANCEL EXISTING COVERAGE'

- ✓ Check box 'M' (medical)
- ✓ Check box 'Change to Individual'
- ✓ Check box 'I voluntarily cancel coverage for all my dependents'

Page 2: Sign and date in the 'AUTHORIZATION' section

CHANGING PRE-TAX STATUS (PTCP)

Complete the PS-404 or complete this change using MYNYSHIP:
Page 1: Complete 1 – 11
Page 2: In box 15 'ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW'

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

Page 2: Sign and date 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, 2021
- ✓ You have obtained other employer sponsored health insurance effective on or prior to January 1, 2022

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 – 11

Page 2: In box 15 'ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW'

- ✓ Elect Opt-out
- ✓ Check the box next to their 'Individual Opt-out' or 'Family Opt-out'

Page 2: Sign and date 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 in the 'ATTESTATION' section

UUP employees are NOT ELIGIBLE to participate in the Opt-out Program.

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

EMPLOYEE BENEFITS DIVISION

Health Insurance Transaction Form for NYS & PE Employees

PS-404 (9/2020)

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. Personal Email Address		
10. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated		Marital Status Date
11. Covered under Medicare? Self: ☐ Yes ☐ No	Spouse/Domestic Partner: ☐ Yes ☐ No	Child: ☐ Yes ☐ No

12. ELECT OR DECLINE COVERAGE

A. Choose a Pre-Tax election

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

You are only eligible for Pre-Tax deductions if newly eligible or if requested during the Pre-Tax Contribution Program (PTCP) Election Period

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 14 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 14) 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)*		

13. CHANGE OR CANCEL EXISTING COVERAGE

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

☐ Change to FAMILY *(Complete box 14)*

- ☐ 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 14 if applicable.

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

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

14. 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: _____

Check One	Check all that apply	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						

15. 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 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, 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 # Hours	Sick Leave Information Hourly Rate of Pay	Date Entered on NYBEAS	Effective Date

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

You only need to complete the following form, PS-409, if you are enrolling in the Opt-out Program.

If you are enrolling in the Opt-out Program, you must submit both the PS-404 and PS-409.

Please following the instructions, *ENROLLING IN THE OPT-OUT PROGRAM* on page 3.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE BENEFITS DIVISION
NYSHIP Opt-out Program Attestation Form

PS-409 (8/19)

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
NYSHIP Opt-out Program Attestation Form

PS-409 (8/19)

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_____

Personal Privacy Protection Law Notification: 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 administering the New York State Health Insurance Program. 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.

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