

DEADLINE

All forms are due by close of business December 29, 2023. Paperwork received after this date will not be processed. **Changes will take effect January 4, 2024,** 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 RECEIPT

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:
 - 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 December 29, 2023, 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 – 12

Page 2: In box 16 '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 – 12

Page 2: In box 15 'CHANGE OR CANCEL EXISTING COVERAGE'

- ✓ In 15 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 – 12

Page 1: 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 – 12

Page 2: In box 15 'CHANGE OR CANCEL EXISTING COVERAGE'

- ✓ Check box 'Medical (10)'
- ✓ Check box 'Change to Individual'
- ✓ Check box 'I voluntarily cancel coverage for 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 – 12

Page 2: In box 16 '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, 2023
- ✓ You have obtained other employer sponsored health insurance effective on or prior to January 1, 2024

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 – 12

Page 2: In box 16 '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.



INSTRUCTIONS: READ AND COMPLETE BOTH PAGES. PLEASE PRINT, CHECK THE APPROPRIATE CHOICES AND SIGN/DATE THE DOCUMENT.

EMPLOYEE INFORMATION

Form section 12: Employee Information. Includes fields for Last Name, First Name, MI, Social Security Number, Gender, Permanent Address, Mailing Address, Work Location, Date of Birth, Telephone Numbers, Personal Email Address, Marital Status, and Medicare information.

13. ELECT OR DECLINE COVERAGE

Form section 13: Elect or Decline Coverage. Includes sub-sections A (Choose a Pre-Tax election) and B (Select a NYSHIP Coverage Option) with checkboxes for Medical, Dental, and Vision coverage.

14. DEPENDENT INFORMATION

Form section 14: Dependent Information. Includes instructions and a table for recording dependent details such as Last Name, First Name, MI, Relationship, Date of Birth, Gender, Address, and Social Security Number.

15. CHANGE OR CANCEL EXISTING COVERAGE

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

Change to FAMILY (Complete box 14 on page 1)

Change to INDIVIDUAL

- | | |
|--|--|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Domestic Partner | <input type="checkbox"/> Termination of Domestic Partnership (Attach completed PS-425.4) |
| <input type="checkbox"/> Newborn | <input type="checkbox"/> Only dependent ineligible due to age |
| <input type="checkbox"/> Request coverage for dependents not previously covered | <input type="checkbox"/> I voluntarily cancel coverage for my dependents |
| <input type="checkbox"/> Previous coverage terminated (proof required) | <input type="checkbox"/> Only dependent died |
| <input type="checkbox"/> Dependent returned to full-time student status (Dental and Vision only) | <input type="checkbox"/> Only dependent graduated (Dental and Vision only) |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 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.

16. ENTER ANNUAL OPTION TRANSFER REQUEST(S) BELOW

Change NYSHIP Option	Change to: <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code <input 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 PTCP 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		Date Entered on NYBEAS	Effective Date
		# Hours	Hourly Rate of Pay		

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.



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 _____

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

AGENCY USE ONLY

Date Received	Date Processed	HBA Initials