



STATE OF NEW YORK
 DEPARTMENT OF CIVIL SERVICE
 THE STATE CAMPUS
 ALBANY, NEW YORK 12239

EMPLOYEE BENEFITS DIVISION
LEAVE WITHOUT PAY HEALTH INSURANCE REMITTANCE NOTICE

PS-436.1 (6/00)(w)

1. **PLEASE SUBMIT THIS FORM WITH EACH REMITTANCE.**
2. **MAKE REMITTANCE PAYABLE TO:** NYS Employees' Health Insurance Pending Account
3. **WRITE YOUR SOCIAL SECURITY NUMBER IN THE UPPER LEFT CORNER OF YOUR CHECK.**
4. **MAIL PAYMENT TO:** NYS Department of Civil Service, Employee Benefits Division, The State Campus, Albany, New York, 12239.

NY HEALTH INSURANCE IDENTIFICATION NUMBER

 Last Name (20 - 32) F.I. (33) M.I. (34)

NO PARTIAL PAYMENTS

 No. and Street Address

 City State ZIP Code

Date: ____/____/____ **TOTAL AMOUNT REMITTED: \$** _____