



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

EMPLOYEE BENEFITS DIVISION
FAMILY MEDICAL LEAVE WITHOUT PAY
HEALTH INSURANCE REMITTANCE NOTICE

PS-436.2 (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 ID NUMBER ON THE FACE 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 F.I. M.I.

 No. and Street Address

 City State ZIP Code

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

FOR OFFICE USE ONLY	
Receipt Number	
Amount Received	Date Received