



This is the application for a waiver of health insurance contributions because of total disability. Any expenses incurred solely for obtaining the attending physician's statement on this application is not a covered medical expense. If you have questions regarding this application for waiver of premium, contact your agency Health Benefits Administrator.

**NOTE:** Enrollees on Family Medical Leave of Absence qualify to apply for a waiver of premium. An employee who is receiving short-term disability benefits under the New York Income Protection Plan is not eligible for a Waiver of Premium. Review your NYSHIP General Information Book to see if you may qualify for a waiver of premium.

**ALL SECTIONS MUST BE COMPLETED IN FULL**

**Instructions:**

- Employee completes Part A
- Agency completes Part B
- Physician completes Part C and mails form directly to New York State Department of Civil Service, Employee Benefits Division, at the above address.
- Employee Benefits Division completes Part D

**PART A**

(To be completed by Employee.)

**PLEASE PRINT OR TYPE**

Name (Print)			NY								
Home Address				ID Number							
City	State	ZIP Code	PA								

**PERSONAL PRIVACY PROTECTION LAW NOTIFICATION**

This information is being requested pursuant to Section 163 of the New York State Civil Service Law and NYCRR Rule 73.4 for the principal purpose of determining eligibility of individuals to participate in these programs and to maintain up-to-date records for covered employees. 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 this information may result in the disapproval of an individual to participate in these programs or a delay in the payment of benefits. This information will be maintained by the Director, Employee Benefits Division, New York State Department of Civil Service, The State Campus, Albany, NY 12239. For further information relating *only* to the Personal Privacy Protection Law, call (518) 457-9375.

**PRESENTATION OF MATERIALLY FALSE INFORMATION IN SUPPORT OF AN INSURANCE APPLICATION OR CLAIM IS PROHIBITED BY ARTICLE 176 OF THE PENAL LAW.**

I hereby apply for a waiver of premium under the New York State Health Insurance Program.

If approved, this approval is contingent on the employee's continuing LWOP status throughout the waiver period. Should the employee return to the payroll, be terminated, retire or resign during the waiver period, this waiver of premium will terminate.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Telephone No. \_\_\_\_\_

**PART B**

(To be completed by Agency.)

**PLEASE PRINT OR TYPE**

Applicant's Title	
Applicant's Birth Date	Date Leave Without Pay Began
Enrollment Option	
Agency Code No.	Tel. No.
Agency Name	
Signature of Health Benefits Administrator	Date

(Over)

