



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

11. ELECT OR DECLINE COVERAGE

A. Select a SEHP Coverage Option
B. Choose a Pre-Tax election
(Only eligible for Pre-Tax deductions if newly eligible or if requested during the PTCP election period, Nov 1-30)

12. CHANGE OR CANCEL EXISTING COVERAGE

A. Change Coverage: Date of Event:
B. Voluntarily Cancel Coverage: Qualifying Event: Event Date:
NOTE: If you are indicating a change in marital status to Divorced or Separated in box 9, please be sure to update the address information for the dependent in box 13 if applicable.

13. DEPENDENT INFORMATION

Must be provided when choosing to enroll in family coverage (use additional sheets if necessary)
Check One: A (Add), D (Delete) or C (Change) Date of Event:
Table with columns: Last Name, First Name, MI, Relationship, Date of Birth, Sex, Address (if different), Social Security Number

14. PREVIOUS COVERAGE INFORMATION		
Complete this section if you are requesting new enrollment or a change to family coverage because you or your dependent's previous coverage was terminated (regardless of whether coverage was previously provided under NYSHIP or another health insurance plan) and you are requesting to have late enrollment of your benefits waived (attach proof: i.e. insurance bill or letter confirming former coverage and the end date of such coverage).		
Previous ID Number	Previous Plan Name	Date Coverage Terminated
Enrollee's Name Under Which Previously Covered:	Last	First Middle Initial

15. REQUEST FOR SEHP BENEFIT CARD	
<input type="checkbox"/> Duplicate Card (Previously issued card remains valid)	For: <input type="checkbox"/> Enrollee <input type="checkbox"/> Individual Dependent
<input type="checkbox"/> Replacement card (Previously issued card lost or stolen)	Name: _____

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 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. Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director of the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 473-2624. For information related to the Health Insurance Program, contact your Agency Health Benefits Administrator. If, after calling your Agency Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344.

AUTHORIZATION	
<p>I have read the Pre-Tax Contribution Program materials 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 <i>Summary of Benefits and Coverage</i> for SEHP. 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.</p> <p>I certify that the information I have supplied is true and correct. I hereby authorize deduction from my salary of the amount required for the coverage indicated above.</p>	
Employee Signature (Required): _____	Date: _____

AGENCY USE ONLY						
Hire Date	Percentage Working	Agency Code	Neg. Unit	Action/Reason	Date of Event	Effective Date

HBA Signature (Required): _____	Date: _____
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