STATE OF NEW YORK
DIVISION OF MILITARY AND NAVAL AFFAIRS
330 OLD NISKAYUNA ROAD
LATHAM, NEW YORK 12110-3514

ANDREW M. CUOMO
GOVERNOR
COMMANDER IN CHIEF

PATRICK A. MURPHY
MAJOR GENERAL
THE ADJUTANT GENERAL

MNHS

7 December 2011

MEMORANDUM FOR All Division of Military and Naval Affairs State Employees

SUBJECT: Health Insurance Opt-Out Program

1. Effective 1 January 2012, the New York State Health Insurance Program (NYSHIP) will offer the Opt-Out Program. This program allows eligible employees, who have other employer-sponsored group health insurance, to opt out of their NYSHIP coverage in exchange for an incentive payment. This program is available to Executive branch employees represented by CSEA and unrepresented Executive branch employees. On an annual basis, employees who elect to participate in the Opt-Out Program will receive incentive payments totaling $1,000 for opting out of individual coverage or $3,000 for opting out of Family coverage.

2. To be eligible for the Opt-Out Program, an employee must meet two eligibility criteria to receive the incentive payment:

a. The employee must have been enrolled in NYSHIP, as a State employee, on 1 April 2011 or on the date first eligible for NYSHIP if that date is after 1 April 2011 through the end of the plan year; and

b. The employee must provide information and attest to having other employer sponsored group health insurance in effect for the Opt-Out period.

**Please Note: To qualify for the Program you must be covered under an employer-sponsored group health insurance plan through other employment of your own or a plan that your spouse, domestic partner or parent has as the result of his or her employment. The other coverage cannot be NYSHIP coverage provided through employment with the State of New York. However, NYSHIP coverage through another employer such as a municipality, school district or public benefit corporation qualifies as other coverage.**

3. Employees who are currently enrolled in NYSHIP and wish to participate in the Opt-Out Program must elect to opt out during the Annual Option Transfer Period and must complete a PS-409 – Opt-Out Attestation Form and a PS-404 – NYS Health Insurance Transaction Form for each year of participation (see attached).

4. The annual incentive amount for opting out of NYSHIP coverage is $1,000 for Individual coverage or $3,000 for Family coverage. The incentive payments will be prorated and reimbursed through the employee's bi-weekly paychecks throughout the year (payable only when an employee is on the payroll and meets the requirements to be eligible for the State to contribute to the cost of NYSHIP coverage).

5. The incentive amount will be credited to the employee's bi-weekly pay check and will be treated as taxable income. The bi-weekly incentive amount will be 38.46 for opting out of individual coverage ($1,000/26 paychecks) or $115.38 for opting out of Family coverage ($3,000/26 paychecks).

6. For 2012, incentive payments to employees participating in the Opt-Out Program will begin as soon as practicable after 1 January; as program changes need to be put in place. After 2012, the annual Opt-Out Program incentive payments will begin coincident with the plan year's rate change and the Option Transfer Period.

7. If you have any questions or need additional information regarding the Opt-Out Program for 2012, please contact Mrs. Tina Lehning at (518) 786-4715 or by e-mail.

FOR THE ADJUTANT GENERAL:

Atchs

MARILYN M. HARTLEY
Director, Human Resources
Management

State of New York
Department of Civil Service
Albany, NY 12239

**EMPLOYEE BENEFITS DIVISION**
**2012 OPT OUT ATTESTATION FORM**
PS 409 12/11

***INSTRUCTIONS:*** *READ THE OPT- OUT PROGRAM INFORMATION ON THE FOLLOWING PAGE AND COMPLETE THE INFORMATION ON THIS PAGE. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.*

## EMPLOYEE INFORMATION

| Name | Social Security Number | Negotiating Unit |
|---|---|---|
| Street Address | City | State / Zip |
| Date of Birth ___/___/___ | Telephone Numbers Home (  ) Work (  ) | Agency Name and Address |
| Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated | 9. Marital Status Date | |

## NYSHIP HEALTH BENEFITS OPT-OUT ELECTION

*Complete this section if you are newly eligible or currently enrolled in NYSHIP.*

Employees must attest below that they are covered under other employer-sponsored health insurance coverage, (Other than the State of New York) to be eligible for the Opt-out Program.

**Check one:**
☐ I am electing to opt-out of Individual coverage in exchange for a $1,000 taxable amount.
☐ I am electing to opt-out of Family coverage in exchange for a $3,000 taxable amount (dependent information must be provided when electing Family opt-out).

**Alternate employer-sponsored group health insurance information (must be provided)**

Name of covered employee_____ Covered employee's Date of Birth_____

Covered employee's SSN_____ Name of covered employee's employer_____

Name and Address of alternate health insurance coverage_____

_____

## ATTESTATION

***All employees complete this section***

I have read the Opt-out Program materials and instructions and I attest to the following:

- I am covered under an alternate employer sponsored health plan and have provided alternate plan information.
- I understand that I must promptly report changes to my status (employment or family) which may change my eligibility during the plan year.
- I understand that during the next annual option transfer period, I must re-elect to opt out or enroll in a NYSHIP benefit option to avoid a NYSHIP late enrollment and experience a gap in coverage.
- I understand that I may choose to opt out of Family coverage *only* if I have NYSHIP eligible dependents.
- I understand that this election is for 2012 only.
- I meet the qualifications to elect the Health Insurance Opt-out Program.

Employee's Signature **(Required)** _____ Signature Date **(Required)** ___/___/_____

Employees who can demonstrate and attest to having other employer-sponsored group health insurance may elect to opt out of NYSHIP's Empire Plan or Health Maintenance Organizations. Employees who elect to opt out of NYSHIP will receive $1,000 for waiving Individual coverage or $3,000 for waiving Family coverage. This amount will be credited to bi-weekly paycheck s as taxable income over the plan year. Unless newly eligible to enroll, employees must be enrolled in NYSHIP Individual or Family coverage prior to April 1st of the previous plan year to be eligible to opt out of that coverage. In order to participate, employees must have other employer-sponsored group health insurance.

There are two times a year when employees may elect to opt out of coverage; as newly eligible for health benefits, and, for currently enrolled employees, during the option transfer period. Only employees who experience a qualifying event will be allowed to withdraw their opt out election and enroll in a health insurance plan mid-year. See instructions below.

INSTRUCTIONS:

Newly eligible employees: Employees may enroll in the Opt-out Program no later than their first date of NYSHIP eligibility. Employees must sign the Opt-out Attestation Form and complete a PS404 Enrollment Form.

Current enrollees: Eligible enrollees may elect the Opt-out Program during the annual Option Transfer Period for an effective date of January 1, 2012. Employees must sign the Opt-out Attestation Form and complete a PS404 Enrollment Form.

During mid-year: Employees who experience a Qualifying Event (QE) must notify their personnel office within thirty (30) days of the QE date in order to enroll in a health insurance plan without a waiting period. Employees must complete a PS404 Enrollment Form.

By signing the Opt-out Attestation, you elect to receive $3,000 (Family coverage waived), or $1,000 (Individual coverage waived); this amount will be credited to your bi-weekly paycheck as taxable income over the plan year.

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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, 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 of the Employee Benefits Division, NYS Department of Civil Service, and Albany, NY 12239. For information concerning the Personal Protection Law, call (518) 457-9375. 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 between the hours of 9:00 a.m. and 3:00 p.m

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This form is not valid if it is not signed and submitted along with a completed PS 404.

State of New York
Department of Civil Service
Albany, NY 12239

# EMPLOYEE BENEFITS DIVISION
## NYS HEALTH INSURANCE TRANSACTION FORM

PS-404 (12/11)

***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 ☐ Male ☐ Female |
| **4.** Street Address / City / State / Zip | | | |
| **5.** Date of Birth | **6.** Telephone Numbers Home ( ) Work ( ) | | **7.** Work location and address |
| **8.** Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated | Marital Status Date | | |
| **9.** Covered under Medicare? Self ☐Yes ☐ No | Spouse/Domestic Partner ☐Yes ☐ No | Child ☐Yes ☐ No | |

## 10. ENTER REQUEST(S) BELOW

| | | | |
|---|---|---|---|
| A. ☐ Request Enrollment- **Individual** | Medical *(10)* *(Select Empire Plan, HMO or opt out)* ☐Empire Plan ☐ HMO Code ☐ Name _____ ☐OPT OUT If choosing opt out, you must also complete the PS409 Opt-out Attestation Form | ☐ Dental *(11)* | ☐ Vision *(14)* |
| B. ☐ Request Enrollment- **Family** (Complete G) | Medical *(10)* *(Select Empire Plan or HMO)* ☐Empire Plan ☐ HMO Code ☐ Name _____ ☐ OPT OUT If choosing opt out, you must also complete the PS409 Opt-out Attestation Form | ☐ Dental *(11)* | ☐ Vision *(14)* |
| C. ☐ Elect Pre-Tax Status for Premium deduction? | D. ☐ Elect Post-Tax Status for Premium deduction? | Initial here to indicate that you have read the Pre-Tax Contribution memorandum. _____ | |
| E. ☐ Decline Coverage | ☐Medical *(10)* ☐ Dental *(11)* ☐ Vision *(14)* *(Process WAV/BEN transaction)* | | |
| F. ☐ Voluntarily Cancel Coverage | ☐Medical *(10)* Qualifying Event: | ☐ Dental *(11)* | ☐ Vision *(14)* |

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

☐ **Change to FAMILY** *(Complete G)*
- ☐ Marriage
- ☐ Domestic Partner
- ☐ First dependent child acquired
- ☐ Dependent returned to full-time student status
- ☐ Request coverage for dependents not previously covered
- ☐ Newborn
- ☐ Previous coverage terminated *(Complete Section 11)*
- ☐ Other _____

☐ **Change to INDIVIDUAL**
- ☐ I voluntarily cancel coverage for my dependents
- ☐ I voluntarily cancel coverage for my domestic partner
- ☐ Only dependent died
- ☐ Only dependent married
- ☐ Only dependent graduated
- ☐ Divorce
- ☐ Only dependent disqualified by age
- ☐ Termination of domestic partnership *(Attach Completed PS-425.4)*
- ☐ Other _____

## DEPENDENT INFORMATION

**Must be provided when choosing to enroll or opt-out of NYSHIP coverage** *(use additional sheets if necessary)*

**Check One: A (Add), D (Delete) or C (Change)**
**Check all that apply: M (Medical), D (Dental), and V (Vision)**
**Date of Event** _____

| A/D/C | M/D/V | Last Name | First Name | MI | Relationship | Date of Birth | Sex | Address *(if different)* | Social Security Number |
|---|---|---|---|---|---|---|---|---|---|
| ☐A ☐D ☐C | ☐M ☐D ☐V | | | | | | | | |
| ☐A ☐D ☐C | ☐M ☐D ☐V | | | | | | | | |
| ☐A ☐D ☐C | ☐M ☐D ☐V | | | | | | | | |
| ☐A ☐D ☐C | ☐M ☐D ☐V | | | | | | | | |
| ☐A ☐D ☐C | ☐M ☐D ☐V | | | | | | | | |

**10. *Continued.*** **ENTER REQUEST(S) BELOW**

H. ☐ Change NYSHIP Option — Change to: ☐ Empire Plan ☐ HMO Code ☐ HMO Name _____ Opt-Out ☐

I. Change Pre-Tax Status — Change to: ☐ Pre-Tax ☐ Post-Tax — Processed only by the Employee Benefits Division during the Pre-Tax Contribution Selection Period (November)

**11. PREVIOUS COVERAGE INFORMATION**

If you were previously enrolled in a NYSHIP plan, or were covered another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.

Previous ID Number

Date the other coverage terminated

Enrollee's Name Under Which Previously Covered — Last — First — Middle Initial

**12. LEAVE WITHOUT PAY AND RETIREMENT STATUS**

**LEAVE WITHOUT PAY**

☐ I wish to continue coverage while I am on authorized leave. I understand that I will be billed for this coverage. ☐ Medical ☐ Dental ☐ Vision

☐ I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll. ☐ Medical ☐ Dental ☐ Vision

**RETIREMENT**

☐ I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage.

☐ I understand the requirements for continuing medical insurance coverage as a retiree and wish to defer my coverage. *(A completed PS-406.2 must be attached.)*

**13. REQUEST FOR EMPIRE PLAN CARD ONLY**

For Health Maintenance Organization (HMO) cards, contact your HMO.

☐ DUPLICATE CARD
(Previously issued card remains valid.)

**FOR**
☐ ENROLLEE
☐ ENROLLEE AND ALL DEPENDENTS
☐ INDIVIDUAL DEPENDENT
Name _____

**Personal Privacy Protection Law Notification**

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**AUTHORIZATION**

I have read the Pre-Tax Contribution Program memorandum and have made my selection on Page 1 of this document, if applicable. I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving State service (vest, retirement, etc.). **I certify that the information I have supplied is true and correct.** I understand that my failure to provide required proof(s) within 28 days (30 days for newborns) 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 hereby ***authorize deduction from my salary or retirement allowance*** of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

→ Employee's Signature **(Required)** _____ Signature Date **(Required)** _____

**AGENCY/EBD USE ONLY**

| Action/Reason | Date of Event | Hire Date | Date of 1st Eligibility (PE only) | Percentage Working | Agency Code | Neg. Unit | Ret. System |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| Retirement Tier | Registration # | Sick Leave Information # Hours | Sick Leave Information Hourly Rate of Pay | Date Entered on NYBEAS | Effective Date |
|---|---|---|---|---|---|
| | | | | | |

**HBA Signature:**

**Date:**