NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE BENEFITS DIVISION
OPT-OUT PROGRAM ATTESTATION FORM

PS-409 (11/15)

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	Marital Status Date	

NYSHIP HEALTH BENEFITS OPT-OUT ELECTION

You must attest to having other employer-sponsored group health insurance to be eligible for the Opt-out Program. Other employer-sponsored group health coverage **cannot be:**

- The result of your or your spouse's, domestic partner's or parent's employment relationship with NYS, or
- The result of your own employment with a NYSHIP Participating Agency (PA) or Participating Employer (PE)

If you are eligible to Opt-out, please **check one:**

I have other coverage as a dependent		I have other coverage through my own employment	
☐	My other coverage is not NYSHIP coverage. I am electing to Opt-out of Individual coverage in exchange for a $1,000 taxable payment ($38.47 over 26 biweekly paychecks).	☐	My other coverage is not NYSHIP coverage. I am electing to Opt-out of Individual coverage in exchange for a $1,000 taxable payment ($38.47 over 26 biweekly paychecks).
☐	My other coverage is not NYSHIP coverage. I am electing to Opt-out of Family coverage in exchange for a $3,000 taxable payment ($115.39 over 26 biweekly paychecks).		
☐	My other coverage is NYSHIP through an employer other than New York State. I understand that I am only eligible to Opt-out of Individual coverage in exchange for a $1,000 taxable payment ($38.47 over 26 biweekly paychecks).	☐	My other coverage is not NYSHIP coverage. I am electing to Opt-out of Family coverage in exchange for a $3,000 taxable payment ($115.39 over 26 biweekly paychecks).

Other employer-sponsored group health insurance information must be provided as indicated below:

Name of covered employee _____ Covered employee's Date of Birth _____

Covered employee's SSN _____

Name of covered employee's employer _____

Effective date of other group health insurance coverage _____

Name and Address of alternate health insurance coverage _____

(You **must** provide either a copy of your health insurance card or a letter from your employer or other health insurance provider confirming current coverage).

ATTESTATION

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

- I meet the qualifications to elect the Health Insurance Opt-out Program.
- I understand that I must promptly report changes that may impact my eligibility or payment amount (e.g., loss of other employer-sponsored coverage, divorce, death, last dependent loses eligibility for NYSHIP coverage) If I fail to do so, I am responsible for any Opt-out Program payments made to me in error. I understand that Opt-out Program payments made to me in error may be recovered as special deductions of up to $200 from my biweekly paycheck.
- I understand that I may choose to opt out of Family coverage only if I have NYSHIP eligible dependents and I am not enrolled in NYSHIP as a dependent or enrollee through NYS or another NYSHIP employer, and that I must provide proof of my dependent's eligibility when enrolling each year.
- I understand that this election is for only one plan year. I must submit the PS-404 and PS-409 again during the next Option Transfer Period if I am eligible and choose to continue in the Opt-out Program.

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

HBA's Signature **(Required)** _____ Signature Date **(Required)** _____

INSTRUCTIONS TO ELECT OPT-OUT:

Employees may elect to opt out of coverage when newly eligible for the Opt-out Program and, for currently enrolled employees, during the annual Option Transfer Period.

Newly eligible employees may enroll in the Opt-out Program no later the last day of the new employee waiting period for coverage. Employees must complete and sign the PS-409 Opt-out Program Attestation Form and the PS-404 Health Insurance Transaction Form.

Current enrollees: Eligible enrollees may elect the Opt-out Program during the annual Option Transfer Period for each plan year. Employees must have been enrolled in NYSHIP Individual or Family health benefits prior to April 1 of the previous plan year or when newly eligible if after April 1 to be eligible to opt out of coverage. Employees must complete and sign the PS-409 Opt-out Program Attestation Form and the PS-404 Health Insurance Transaction Form.

NOTE: If an employee maintained continuous enrollment in a NYSHIP health plan, and changed coverage from Individual coverage to Family coverage due to a qualifying event (e.g., requests to cover a new spouse within 30 days from the date of marriage), the employee may be eligible for the family Opt-out incentive payment for the following plan year. If the request to change health plan coverage is subject to late enrollment, the employee would only be eligible for the individual Opt-out incentive payment.

INSTRUCTIONS TO ENROLL IN NYSHIP HEALTH BENEFITS

Employees who participate in the Opt-out Program may enroll in NYSHIP health benefits during the next annual Option Transfer Period. Employees must complete a PS-404 Health Insurance Transaction Form.

Additionally, employees enrolled in the Opt-out Program who experience a PTCP qualifying event, such as a change in family status (e.g., marriage, birth, death or divorce) or loss of coverage, must notify their personnel office within thirty (30) days of the event date in order to enroll in a health plan without satisfying a late enrollment waiting period. Opt-out enrollees who experience a qualifying event but fail to notify their personnel office within thirty (30) days of the date of event may enroll in a NYSHIP health plan after satisfying a late enrollment waiting period. Employees must complete a PS-404 Health Insurance Transaction Form to request enrollment.

Opt-out enrollees who **have not** experienced a PTCP qualifying event may not enroll in a NYSHIP health plan for the remainder of the plan year. They must remain in the Opt-out Program and wait for the next Annual Option Transfer Period to enroll in a NYSHIP health plan.

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, 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 4:00 p.m.

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