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

EMPLOYEE BENEFITS DIVISION
2015 OPT OUT ATTESTATION FORM

PS 409 (11/14)

EMPLOYEE INFORMATION

Name | Social Security Number | Negotiating Unit

Street Address | City | State | Zip

Date of Birth _____/_____/_____

Telephone Numbers
Primary ( ) Work ( )

Agency Name and Address

Marital Status
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Marital Status Date

NYSHIP HEALTH BENEFITS OPT-OUT ELECTION

Employees must attest that they are covered under another employer-sponsored group health insurance plan to be eligible for the NYSHIP Opt-out Program. (CSEA and PEF employees may be subject to additional contract provisions/stipulations and should consult with their Health Benefits Administrator before electing Opt-out).

Check one:

☐ I have other NYSHIP coverage and I am electing to Opt-out of Individual coverage in exchange for a $1,000 taxable amount.
(New York State employees may not maintain two NYSHIP family plans, regardless if one plan is the Opt-out program)

☐ I have other employer-sponsored group health insurance coverage **that is not NYSHIP coverage**, and I am electing to Opt-out of Individual coverage in exchange for a $1,000 taxable amount.

☐ I have other employer-sponsored group health insurance coverage **that is not NYSHIP coverage,** and I am electing to Opt-out of Family coverage in exchange for a $3,000 taxable amount. I understand that all dependent information must be provided when electing Family opt-out.

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 _____

ATTESTATION

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

- I am covered under another employer-sponsored group health plan that is in effect as of the date I opt-out of NYSHIP coverage and I have provided accurate information regarding my other employer-sponsored coverage.
- I understand that I must promptly report changes to information I have provided above which may impact my eligibility (e.g., loss of other employer-sponsored coverage, divorce, death, last dependent loses eligibility for NYSHIP coverage) and if I fail to do so, I am responsible for any Opt-out payments made to me in error.
- 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 elsewhere.
- I understand that this election is for 2015 only. In order to enroll in the Opt-out Program for 2016, I must submit the PS-404 and PS-409 again during the next Option Transfer Period.
- I meet the qualifications to elect the Health Insurance Opt-out Program.

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

Eligible employees who attest to having other employer-sponsored group health insurance may elect to opt out of NYSHIP coverage in exchange for an incentive payment. Employees who elect to opt-out of NYSHIP will receive $1,000 ($38.47 over 26 biweekly paychecks) for Individual Opt-out or $3,000 ($115.39 over 26 biweekly paychecks) for Family Opt-out. This amount will be credited to biweekly paychecks as taxable income over the plan year. Employees who elect to opt out of NYSHIP and have other NYSHIP coverage are only eligible for the individual incentive payment.

Unless newly eligible to enroll, employees must have been enrolled in NYSHIP Individual or Family health benefits prior to April 1st of the previous plan year to be eligible to opt-out of coverage.

Newly eligible employees must make their Opt-out election prior to the end of the NYSHIP waiting period if they are a new State employee or within 30 days of the effective date of a change in bargaining unit representation. If an employee maintains continuous enrollment in NYSHIP, and changes 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 would be eligible for the family incentive payment for the following plan year. If the request to change coverage is subject to late enrollment, the employee would only be eligible for the individual incentive payment.

There are two circumstances when employees may elect to opt out of coverage; when newly eligible for the Opt-out and, for currently enrolled employees, during the Annual Option Transfer Period. Late submissions will not be accepted.

INSTRUCTIONS TO OPT-OUT:

Newly eligible employees: 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 Attestation Form and the PS-404 Enrollment Form.

Current enrollees: Eligible enrollees may elect the Opt-out Program during the Annual Option Transfer Period for each plan year. Employees must complete and sign the PS-409 Opt-out Attestation Form and the PS-404 Enrollment Form.

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 PS404 Enrollment Form.

Additionally, employees 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 a waiting period. Employees who experience a qualifying event but fail to notify their personnel office within thirty (30) days of the event, may enroll in NYSHIP health benefits after a late enrollment waiting period. Employees must complete a PS404 Enrollment Form to request enrollment.

Employees who **have not** experienced a PTCP qualifying event, may not enroll in NYSHIP health benefits arbitrarily. They must remain in the Opt-out Program and wait for the next Annual Option Transfer Period to enroll in NYSHIP health benefits.

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.