

OPEN ENROLLMENT CHANGE FORM

NYS Department of Civil Service
The State Campus
Albany, NY 12239

Health Insurance Transaction Form
Graduate Student Employee Union
Student Employee Health Plan
PS-404G (12/01L) Page 2

11. 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		Date Coverage Terminated	
Enrollee's Name Under Which Previously Covered	Last	First	Middle Initial

12. REQUEST FOR GSEU BENEFIT CARD (Student Employee Health Card) ONLY	
<input type="checkbox"/> DUPLICATE CARD (Previously issued card remains valid.) <input type="checkbox"/> REPLACEMENT CARD (Previously issued card(s), lost or stolen, become invalid.)	FOR: <input type="checkbox"/> ENROLLEE <input type="checkbox"/> ENROLLEE AND ALL DEPENDENTS <input type="checkbox"/> INDIVIDUAL DEPENDENT Name _____

Personal Privacy Protection Law Notification

This information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the NYS 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), (c) 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, The State Campus, 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.

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 COBRA Continuation Coverage rights for myself and/or my dependents. I certify that the information I have supplied is true and correct. I understand that my failure to provide required proof(s) within 30 days of the end of the initial or annual enrollment periods or within 30 days of a qualifying event 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 <i>authorize deduction from my salary</i> 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)