EMPIRE HEALTH INSURANCE FORM

(Last Name:) (First Name:) (Emp. #) (Date of Birth) (Social Security#)

Coverage:

(Address:)

Coverage	
Individual:	
Family:	

Dependents

Last Name:	First Name:	Relationship	Social Security #	Date of Birth:

Date of Hire (or) Change Request: ____________

Effective Date: ____________

Job Title: ____________

Effective Date of Cancellation: ____________

Last day of work: ____________

Termination Reason: ____________

CHANGES:

Add Dependents: Yes		List added dependents above:			
Delete Dependents: Yes					
Enroll in Cobra Status	Yes		No		
Enroll in Vested Status	Yes		No		
Enroll in Survivor Status	Yes		No		Graduation Date:
Enroll in Student Extension	Yes		No		
Enroll in Retiree Status	Yes		No		
Enroll in Medicare Status	Yes		No		
Retirement Date:			ERS		TRS

Tier #	Retirement #

FM Ded. Set Up $	
Entered NYBeas	
Proofs in file:	
Empire Bill:	
Cobra Sent	

Pension Deduction: | Yes | No |

Pension Deduction Code: ____________

(Signature:) (Date:)

Empire Transaction Form 6/11/01

STATE OF NEW YORK
DEPARTMENT OF CIVIL SERVICE
THE W. AVERELL HARRIMAN
STATE OFFICE BUILDING CAMPUS
ALBANY, NEW YORK 12239

EMPLOYEE BENEFITS DIVISION

NYS GOVERNMENT EMPLOYEES' HEALTH INSURANCE

COORDINATION OF BENEFITS FORM

PS-600 (12/97)

The State Health Insurance Program has a Coordination of Benefits Provision that applies when you or any dependent receive benefits under more than one health insurance program. Coordinating benefits helps to contain the cost of health care and can save you some out-of-pocket expenses when balances remain after one carrier has made its claim payment.

Please return the completed form to your agency Health Benefits Administrator.

ALWAYS COMPLETE SECTION I.– EMPLOYEE INFORMATION

SECTION I. EMPLOYEE INFORMATION

NAME: LAST	FIRST	M.I.	CIRCLE ONE PREFIX XXXX or (PA)	SOCIAL SECURITY NUMBER	DATE OF BIRTH
STREET ADDRESS			MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed		SEX ☐ Male ☐ Female
CITY	STATE	ZIP CODE	EMPLOYING AGENCY Huntington UFSD		AGENCY CODE 3213

SECTION II.

OTHER COVERAGE A:

NAME OF DEPENDENT WITH OTHER COVERAGE	POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH	SEX
NAME OF OTHER EMPLOYER	ADDRESS OF OTHER EMPLOYER		
NAME OF OTHER INSURANCE CARRIER	ADDRESS OF OTHER INSURANCE CARRIER		
TYPE OF COVERAGE ☐ Individual ☐ Family	COMMENTS		

DO NOT WRITE IN THIS SPACE

Status | T. Carrier | Emp. Code | Carrier Code | Cov. | Sex | ... Sex

OTHER COVERAGE B:

NAME OF DEPENDENT WITH OTHER COVERAGE	POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH	SEX
NAME OF OTHER EMPLOYER	ADDRESS OF OTHER EMPLOYER		
NAME OF OTHER INSURANCE CARRIER	ADDRESS OF OTHER INSURANCE CARRIER		
TYPE OF COVERAGE ☐ Individual ☐ Family	COMMENTS		

DO NOT WRITE IN THIS SPACE

Status | T. Carrier | Emp. Code | Carrier Code | Cov. | Sex | ... Sex

IF ADDITIONAL DEPENDENTS HAVE OTHER COVERAGE, CHECK HERE ☐

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION: This information is being requested pursuant to §163 of the New York State Civil Service Law for the purpose of determining the availability of benefit coordination and to maintain up-to-date records for covered employees and their dependents. This information will be used in accordance with §96(1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide this information may result in a delay in the payment of benefits. While this information will be maintained by the Insurance Carrier, the Director of the Employee Benefits Division, Department of Civil Service, The W. Averell Harriman State Office Building Campus, Albany, NY 12239, is responsible for these records and information contained therein may not be released without the Director's authorization.

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT

SIGNATURE: ______________________ DATE: ______________

FOR FURTHER INFORMATION ON THE COORDINATION OF BENEFITS FORM, CONTACT YOUR PERSONNEL OFFICE

Agency Information: