NEW YORK STATE OF OPPORTUNITY. **Department of Civil Service**

EMPLOYEE BENEFITS DIVISION
Health Insurance Transaction Form
Student Employee Health Plan (SEHP) PS-404G (8/18)

INSTRUCTIONS: READ AND COMPLETE BOTH SIDES/PAGES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.

EMPLOYEE INFORMATION *(All employees must complete)*

1. Last Name: de Oliveira Gomes | First Name: Marlon | MI:
2. Social Security Number: 897-75-9177
3. Sex: ☑ Male ☐ Female

4. Permanent Address Street: 645 Belle Terre Road, Apartment 74 | City: Port Jefferson | State: NY | Zip: 11777

5. Mailing Address (If different) Street: | City: | State: | Zip:

6. Work Location & Address Street: Department of Mathematics, 100 Nicolls Road | City: Stony Brook | State: NY | Zip: 11794

7. Date of Birth: 03/27/92

8. Telephone Numbers: Primary (631) 4063271 Work ( )

9. Marital Status: ☐ Single ☑ Married ☐ Widowed ☐ Divorced ☐ Separated | Marital Status Date: 06/12/2013

10. Covered under Medicare? Self: ☐ Yes ☑ No Spouse/Domestic Partner: ☐ Yes ☑ No Child: ☐ Yes ☑ No

11. ELECT OR DECLINE COVERAGE

A. Select a SEHP Coverage Option

- ☐ **Individual Enrollment**
- ☑ **Family Enrollment** *(Complete box 13)*
- ☐ **Decline Coverage**

B. Choose a Pre-Tax election
(Only eligible for Pre-Tax deductions if newly eligible or if requested during the PTCP election period, Nov 1-30)

- ☑ **Elect Pre-Tax Status** for Premium deduction
- ☐ **Elect After-Tax Status** for Premium deduction

12. CHANGE OR CANCEL EXISTING COVERAGE

A. Change Coverage: **Date of Event:** _____

☐ **Change to FAMILY** *(Complete box 13)*

- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ First dependent child acquired
- ☐ Arrival of eligible dependent in United States
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Other: _____

☐ **Change to INDIVIDUAL**

- ☐ Divorce
- ☐ Termination of Domestic Partnership *(Attach completed PS-425.4)*
- ☐ Only dependent ineligible due to age
- ☐ Only dependent died
- ☐ Only dependent married
- ☐ I voluntarily cancel coverage for my dependents
- ☐ I voluntarily cancel coverage for my domestic partner
- ☐ Other: _____

NOTE: If you are indicating a change in marital status to Divorced or Separated in box 9, please be sure to update the address information for the dependent in box 13 if applicable.

B. Voluntarily Cancel Coverage: ☐ Qualifying Event: _____ Event Date: _____

NOTE: If you are enrolled in the Pre-Tax Contribution Program, you may make changes during the Annual Option Transfer Period or when experiencing a qualifying event.

13. DEPENDENT INFORMATION

Must be provided when choosing to enroll in family coverage *(use additional sheets if necessary)*

Check One: A (Add), D (Delete) or C (Change) **Date of Event:** _____

↓	Last Name First Name MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security Number
☑ A ☐ D ☐ C	Lima de Oliveira Gomes, Jessica	Wife	04/13/91	F		884217889
☑ A ☐ D ☐ C	Lima de Oliveira Gomes, Julia	Daughter	04/03/09	F		
☐ A ☐ D ☐ C						

14. 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	Previous Plan Name	Date Coverage Terminated

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

15. REQUEST FOR SEHP BENEFIT CARD

☐ Duplicate Card
(Previously issued card remains valid)

☐ Replacement card
(Previously issued card lost or stolen)

For: ☐ Enrollee
☐ Individual Dependent

Name: _____

Personal Privacy Protection Law Notification

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. 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) 473-2624. 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.

AUTHORIZATION

I have read the Pre-Tax Contribution Program materials and have made my selection on Page 1 of this document. I understand that if my coverage is declined or canceled, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date and may forfeit the right to such coverage after leaving State service (vest, retirement, etc.). I am aware of how to obtain a current *Summary of Benefits and Coverage* for SEHP. I understand that my failure to provide required proof(s) within 30 days 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 certify that the information I have supplied is true and correct. I hereby authorize deduction from my salary of the amount required for the coverage indicated above.

Employee Signature (Required): _____ **Date:** _____

AGENCY USE ONLY

Hire Date	Percentage Working	Agency Code	Neg. Unit	Action/Reason	Date of Event	Effective Date

HBA Signature (Required): **Date:**