NYSHIP
New York State Health Insurance Program

# REQUEST FOR COVERAGE UNDER THE YOUNG ADULT OPTION

**(New York State agencies and Participating Employers)**

NYS Department of Civil Service
Employee Benefits Division
Albany, NY 12239

**Directions:** To apply for coverage under the Young Adult Option, please complete this form and return it to the address listed above with full payment for the first month's premium. Please provide the necessary documentation to establish eligibility.
Checks should be made payable to 'Employee Insurance Pending Account.'
**If you are NOT enrolling during open enrollment, proof of loss of previous coverage is required.**
**Please note:** Election for coverage can be made by either the Parent Enrollee OR the eligible Young Adult.

## YOUNG ADULT INFORMATION

| **Name and Mailing Address of Young Adult:** | **Social Security Number:** |
|---|---|
| | **Telephone Number (with area code):** |

## PARENT ENROLLEE INFORMATION

| **Name and Mailing Address of Parent Enrollee:** | **Social Security Number:** |
|---|---|
| | **Telephone Number (with area code):** |

**To qualify, the Young Adult must be able to check "True" for all of the following statements:**

| | | |
|---|---|---|
| 1. | I am the child or step-child of a current NYSHIP enrollee. | ☐ True ☐ False |
| 2. | I am unmarried. | ☐ True ☐ False |
| 3. | I am NOT eligible for other group health plan coverage. | ☐ True ☐ False |
| 4. | I am NOT enrolled in Medicare. | |
| 5. | I am under the age of 30 years. (Date of Birth: _____/_____/____) | ☐ True ☐ False |

**Proofs Required for Young Adult Option** If you are NOT enrolling during open enrollment, proof of loss of coverage is required.

| **YOUNG ADULT CHILD:** | **Provided?** |
|---|---|
| Copy of Birth Certificate | ☐ Yes ☐ No |
| **YOUNG ADULT STEP-CHILD:** | |
| Copy of Birth Certificate | ☐ Yes ☐ No |
| Copy of Marriage Certificate of Parent Enrollee | ☐ Yes ☐ No |

## PLAN SELECTION

I am making an election for enrollment in the Young Adult Option. To the best of my knowledge and belief, all of the answers provided on this form are true and correct. I have read and understand the rules regarding termination of coverage on Page 2 of this form. Only ONE signature is required, either the Young Adult OR the Parent Enrollee.

| | |
|---|---|
| ☐ I wish to enroll in the same plan as my Parent Enrollee.<br>☐ I wish to enroll in a different plan than my Parent Enrollee.<br>**Enter Plan Code:**_____ | Visit https://www.cs.state.ny.us/yao for rates and information about the different NYSHIP plans available under the Young Adult Option. |

**Parent Enrollee or Young Adult Signature:** _____ **Print Name:** _____

**Billing should be sent to:** ☐ **Parent Enrollee** ☐ **Young Adult** **Date:** _____

In order for the Employee Benefits Division to speak to the Parent Enrollee regarding a Young Adult's coverage, we must have a HIPAA Release Form (EBD-543) completed and signed by the Young Adult.

**YOUR COVERAGE WILL TERMINATE WHEN**:

1. You voluntarily elect to terminate your coverage;
2. Your parent is no longer enrolled in NYSHIP;
3. You no longer meet the eligibility requirements for the Young Adult Option; or
4. The NYSHIP premium for the Young Adult is not paid in full within the 30-day grace period.

**Please note that termination of coverage under the Young Adult Option does NOT cause a "qualifying event." Therefore, the Young Adult has no right to federal COBRA coverage or State continuation coverage when the Young Adult Option ends.**

Please complete this form and return it to the following address with full payment for the first month's premium.

NYS Department of Civil Service
Employee Benefits Division – YAO
Alfred E. Smith State Office Building
Albany, NY 12239

Checks should be made payable to 'Employee Insurance Pending Account.'

Please provide the necessary documentation to establish eligibility.

**FOR AGENCY USE ONLY:**

This application is: ☐ Approved ☐ Denied

**If application is denied, reason for denial:**

Signature of employer, plan administrator, or other party responsible for administration for the Plan.

**Signature:** _____ **Date:** _____

**Print Name:** _____ **Phone: (518) 457-5754 or 1-800-833-4344**

**Personal Privacy Protection Law Notification:** The information you provide on this form is requested for the principal purpose of authorizing the use and/or disclosure of protected health information pursuant to 45 CFR 164.508. Failure to provide the information may interfere with our ability to use or disclose protected health information necessary to administer NYSHIP and NYPERL. The information will be maintained by the Director of the Employee Benefits Division, Department of Civil Service, Albany, NY 12239. The information will be used in accordance with Public Officers Law section 96(1), also known as the Personal Privacy Protection Law. For information on the Personal Privacy Protection Law, call (518) 457-9375. If you have any questions regarding this form or your insurance coverage, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m. Monday through Friday.