EMPIRE HEALTH INSURANCE FORM

(Last Name:)		(Emp. #)	(Date of Birth)	(Social Security#) <u>Coverage:</u>						
(Address:)	oliote in transcription de la companie de la compa			and the second section of the section of t	Individual:					
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Date of Hire (or) Change Request:			Effective Date of Cancellation:							
Effective Date:		Last day of work:								
Job Title:				Termination	Reason:	opensore i politici de una sil proprio mala del del milita de la Carle de Silveria.				
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Add Dependents:	Yes	dependents abov	e: .							
Delete Dependents:	Yes									
Enroll in Cobra Status	3	Yes		No						
Enroll in Vested Statu	IS	Yes		No						
Enroll in Survivor Sta	Yes		No	Grad	duation Date:					
Enroll in Student Extension				No						
Enroll in Retiree Statu	Yes		No							
Enroll in Medicare Sta	Yes	٠	No							
Retirement Date:				ERS	TRS	·				
Tier#		Retiremen	nt #	70.00	FM Ded. Set Up 8					
					Entered NYBeas					
Pension Deduction:	Yes	No			Proofs in file:					
Pension Deduction C	code:				Empire Bill:					
					Cobra Sent					
(Signature:)				(Date:)						
Empire Transaction	on Form 6/11,	0 1		•						



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											
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		CERTIFY THAT	THE ABOVE	IS TRUE	EAN	D CORF	rec'	T					
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FOR FURTHER INFORMATION ON THE COORDINATION OF BENEFITS FORM, CONTACT YOUR PERSONNEL OFFICE
Agency Information: