NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE BENEFITS DIVISION

Application for Waiver of Empire Plan Premium

PS-452 (10/2020 L)

This is the application for a waiver of Empire Plan premium. It applies to New York State, Participating Employers or Participating Agencies enrollees who are on a **Leave of Absence** due to a total disability. If you have questions regarding eligibility or this application for waiver of Empire Plan premium refer to your General Information Book or contact your agency Health Benefits Administrator.

You are **NOT** eligible for the waiver if you are still receiving income through salary, leave accruals, Short-Term Disability Income Protection Plan benefits, Workers' Compensation, Paid Family Leave or retirement allowance.

Eligibility for a Waiver of Empire Plan Premium

To qualify for a waiver of your Empire Plan premium, you must meet ***all four*** of the following requirements:

1. You are currently enrolled in The Empire Plan;
2. You have been totally disabled as a result of illness or injury;
3. You are on authorized Leave Without Pay, unpaid Family and Medical Leave or covered under Preferred List or UUP retrenchment provisions.

   For District Council 37, M/C and Legislature: If you receive Long-Term Disability payments from the New York State Income Protection Plan or Legislative Long-Term Disability Protection Plan, and you pay the full cost of your premium, you are eligible to apply for a waiver;

   AND
4. You do not owe any outstanding premium for coverage prior to the unpaid leave.

You must apply during the period in which you meet the eligibility requirements for a waiver.

You may *not* apply after you return to the payroll or vest, retire or separate from your employer. The application will be returned to you if it is not complete.

See page 2 for instructions on how to apply.

What Happens Next

The Plan Administrator for The Empire Plan will review the completed application and determine the period of disability or disapprove, based on the information provided in the application. The Plan Administrator will then forward their recommendation to the Employee Benefits Division (EBD) at the Department of Civil Service who will make the final determination on your eligibility for the waiver of premium. EBD will notify you if your waiver has been granted.

Employees of New York State agencies should address any questions to the Leave Without Pay Unit at 1-800-833-4344. Employees of Participating Agencies or Participating Employers should address questions to their employing agency's Health Benefits Administrator.

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Instructions for Completing the PS-452 Application for Waiver of Empire Plan Premium

1. The ENROLLEE completes their portion of the form and ***provides pages 2 and 3 to the treating physician.***
2. The PHYSICIAN completes their portion of the form (page 3). Once complete, the Enrollee or the physician **sends *pages 2 and 3 to: UnitedHealthcare, PO Box 1600 Kingston, New York 12402-1600***
3. The PLAN ADMINISTRATOR (UnitedHealthcare) completes their portion (the bottom of page 2) and ***mails page 2 only to the Employee Benefits Division of the Department of Civil Service.***

Please note that while the plan administrator is reviewing the information, they may reach out to the enrollee or the treating physician for more information.

Enrollee Portion

Complete this portion of the form and then submit pages 2 and 3 to the treating physician.
Keep a copy of the completed form for your records.

Last Name	First Name		Middle Initial
Telephone No.	Empire Plan ID Number		Date of Birth
Home Address (No. and Street)	City	State	Zip Code

I am applying for: (check one)
☐ **My FIRST waiver of Empire Plan premium related to this sickness/injury**
☐ **An ADDITIONAL waiver of Empire Plan premium related to this sickness/injury**

Personal Privacy Protection Law Notification

The 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 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), (e) 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, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

HIPAA Privacy Authorization to Release Protected Health Information

By my signature below, I authorize the attending physician to provide my Plan administrator with health information (to be indicated in the Physician portion of this form) regarding my mental or physical disability. I also authorize the insurance carrier to disclose its determination (to be indicated in the Plan Administrator Portion of this form) to the Department of Civil Service. The purpose of these disclosures is to determine my eligibility for a waiver of health insurance contributions. I understand that I may revoke this authorization in writing at any time, as described in the NYSHIP Notice of Privacy Practices. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected by HIPAA.

PRESENTATION OF MATERIALLY FALSE INFORMATION IN SUPPORT OF AN INSURANCE APPLICATION OR CLAIM IS PROHIBITED BY ARTICLE 176 OF THE PENAL LAW.

I hereby apply for a waiver of premium under the New York State Health Insurance Program. If approved, this approval is contingent on the employee's disability and Leave Without Pay status throughout the waiver period. Should I return to the payroll, be terminated, retire, vest or resign during the waiver period, this waiver of premium will terminate.

Enrollee Signature: _____	**Date:** _____

Plan Administrator Portion

This portion of the form is to be completed by the appropriate plan administrator for The Empire Plan. Once complete, send this page only to: The Department of Civil Service, Employee Benefits Division (EBD), Albany, NY 12239 or by fax to 518-485-5590

☐ **Approved:** _____ (Date first disabled (effective date)) **To:** _____ (Disability through (certified until))	☐ **Not Approved**
Authorized Representative **Signature:** _____	**Date:** _____

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Physician Portion
All boxes below to be completed by the treating physician.
Once complete, all pages must be sent to UnitedHealthcare.

Mail To: UnitedHealthcare
PO Box 1600
Kingston, New York 12402-1600

Physician's Name		Physician's Phone Number
Physician's Address	City	State Zip Code
Patient Name		Empire Plan ID Number

Is this employee currently totally disabled? ☐ Yes ☐ No

When did the total disability first prevent the employee from performing their regular work duties? Date: _____

When did you FIRST treat the employee for this disability? Date: _____

When did you LAST examine the employee? Date: _____

When do you estimate the employee will be able to resume their regular work duties? Date: _____

Complete description of medical condition, including diagnosis, prognosis, current status and service being received:

(If more space is necessary, attach additional pages.)

PLEASE NOTE: Unless all questions are answered completely, a determination cannot be made.

Physician's Signature: _____ Date: _____