NYSHIP
New York State Health Insurance Program

REQUEST FOR COVERAGE UNDER THE YOUNG ADULT OPTION

(Participating Agencies)

Submit Form and Payment to the Health Benefits Administrator at Your Parent's Employing Agency

Directions: To apply for coverage under the Young Adult Option, please complete this form and return it to the Health Benefits Administrator at your parent's Employing Agency with full payment for the first month's premium. Please provide the necessary documentation to establish eligibility.

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:	**Social Security Number:**
	Telephone Number (with area code):

To qualify, the young adult must be able to check "Yes" for all of the following statements:

1.	I am the child or step-child of a current NYSHIP enrollee.	☐ Yes ☐ No
2.	I am unmarried.	☐ Yes ☐ No
3.	I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
4.	I am NOT enrolled in Medicare.	☐ Yes ☐ No
5.	I am under the age of 30 years. (Date of Birth: _____/_____/____)	☐ Yes ☐ No

Proofs Required for Young Adult Option

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 Young Adult Option.

Please see the Health Benefits Administrator at your Parent's Employing Agency for rate and Plan information.

Enrollee OR Young Adult Signature: _____ **Print Name:** _____

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

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

5. 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 <u>NOT</u> 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 Health Benefits Administrator at your parent's Employing Agency with full payment for the first month's premium. 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:** _____