State of New York
Department of Civil Service
Alfred E. Smith State Office Bldg.
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION
APPLICATION FOR WAIVER OF PREMIUM

This is the application for a waiver of health insurance contributions because of total disability. Any expense incurred solely for obtaining the attending physician's statement on this application is not a covered medical expense. If you have questions regarding this application for waiver of premium, contact your agency Health Benefits Administrator.

NOTE: Enrollees on Family Medical Leave of Absence qualify to apply for a waiver of premium. An employee who is receiving short-term disability benefits under the New York Income Protection Plan is not eligible for a Waiver of Premium. Review your NYSHIP General Information Book to see if you may qualify for a waiver of premium.

INSTRUCTIONS FOR COMPLETING THE PS-452 APPLICATION FOR WAIVER OF PREMIUM

1. **Enrollee** completes **Part A**.
2. **Agency** completes **Part B**, (Parts A and B must be completed before any other parts of the form are completed to ensure confidentiality of the dependent's medical information).
3. Leave **Part C blank.** United Health Care to complete last.
4. **Attending physician** completes **Part D** (attending physician cannot complete this section until Parts A and B are complete).

PART A (To Be Completed by Enrollee) ***Please print or type***

Enrollee's Name (Print)	Health Insurance ID Number	Date of Birth	
Home Address (No. and Street)	City	State	Zip Code

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 continuing Leave Without Pay status throughout the waiver period. Should the employee return to the payroll, be terminated, retire or resign during the waiver period, this waiver of premium will terminate.

Enrollee's Signature	**Telephone No.**	**Date**

PART B (To Be Completed by Employing Agency) ***Please print or type***

Effective Date of Leave Without Pay Status	Enrollee's Health Insurance Coverage: ☐ Individual ☐ Family	Health Insurance Option - Empire Plan
Employing Agency	Telephone Number	Agency Code
Authorized Signature		**Date**

PART C (To be completed by the United HealthCare) ***Please print or type***

☐ Approved _____ (Date first disabled (effective date) (mm/dd/yy)) to _____ (Disability through (mm/dd/yy))	☐ Not Approved
Signature	**Date**

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Personal Privacy Protection Law Notification

The information you provide on this application is requested for the principal purpose of enabling the NYS Department of Civil Service to process your request for a waiver of health insurance premium in the New York State Health Insurance Program. The information will be used in accordance with Public Officers Law Section 96 (1) also known as the Personal Privacy Protection Law. Failure to provide the information requested may prevent the Department from processing this application. This information will be maintained by the Director, Division of Employee Benefits, NYS Department of Civil Service, Albany, NY 12239. For information related only to the Personal Privacy Protection Law, call (518) 457-9375. **For information, related to your Eligibility for Waiver of Premium, contact your Agency Health Benefits Administrator. If, after calling your Health Benefits Administrator, you need more information concerning the waiver of premium, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.**

PART D (To Be Completed by Attending Physician) *Please print or type*

Enrollee's Name	**Health Insurance ID Number**
Physician's Name	**Physician's Address**
Telephone Number (including area code)	

When did the disability first prevent the employee from performing his or her regular duties?	_____ (mm/dd/yy)
Is the employee currently disabled?	☐ Yes ☐ No
On what date did you FIRST treat the employee for this disability?	_____ (mm/dd/yy)
On what date did you LAST examine the employee?	_____ (mm/dd/yy)
When do you estimate the employee will be able to resume his or her regular duties?	_____ (mm/dd/yy)

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**

Enrollee or attending physician mails the completed form to:

United HealthCare
Eligibility Unit
505 Boices Lane
Kingston, New York 12402