New York State Correctional Officers & Police Benevolent Association, Inc.

102 Hackett Blvd., Albany, NY 12209
(518) 427-1551 - 518.426.1635 fax
www.nyscopba.org - retirement@nyscopba.org

Revised 2.1.2021

NYSCOPBA Member:

Congratulations on your retirement! Enclosed please find several forms and information to assist you getting your retirement started. We hope you find this information helpful and we are here to help you should you need assistance filling out the forms or understanding the information provided. Below is a summary of what's included;

- **Helpful contact information for retirees**
- **How to Retire Checklist**
- **Application for NYSCOPBA's Retirement Chapter**
- **OSC Form 6037-** Application for Service Retirement
- **OSC Form 6399-** Retirement Election Form for Tier 3, 4, 5 & 6
- **OSC Form 6370-** EFT Direct Deposit Enrollment Application
- **OSC Form W-4P-** Withholding Certificate for Pension
- **Dental Options in Retirement**
- **Vision Options in Retirement**
- **Life Insurance Options in Retirement**

Other useful information

- **Health Insurance upon Retirement**- When you retire from state service, your health insurance coverage continues automatically with the same plan (Empire or a HMO) and the same coverage level (individual or family) that you had as an active member (unless you make a change). **It usually takes Civil Service a few months to send you a bill (premium notice) and it will be retroactive to your retirement date so be aware you first bill will be relatively expensive.**
- **Applying Sick Leave Credits Toward Health Insurance Premiums**- You have the option of applying your accumulated sick leave (up to a maximum of 1600 hours) toward a credit to offset your health insurance premiums in retirement. Your sick leave accruals are converted into a monthly dollar amount (based on age, accruals, salary, etc.). This credit is automatically applied toward your health insurance premium. You can choose to take the single annuitant option (100% of the sick leave credit amount) which ends upon you passing away or the dual annuitant option (70% of the sick leave credit amount) credit continues to be applied to your dependent's coverage. This process must be done before your retirement; **you cannot change your election on or after your retirement date.**
- **Medicare and NYSHIP-** Under the Empire Plan, when you or your dependent/domestic partner become Medicare eligible, you (or your dependent/domestic partner) must sign up for Medicare Parts A & B **(do not sign up for Parts C or D)** effective the day your Medicare becomes primary. The State reimburses you for the cost of Medicare Part B (also your dependent/domestic partner when they become Medicare eligible) so there is no cost for Medicare. At that point, Medicare becomes your primary coverage and the Empire Plan becomes secondary. Retirees covered under an HMO should check with that HMO in regards to their Medicare coverage. (NOTE: Be advised that once a Retiree or dependent/domestic partner become Medicare-primary, they lose eligibility for continuation of their COBRA Dental and Vision benefits. At that point, they can consider the other dental/vision options available to them).
- ***NOTE:*** Be advised that if you are retired and are not Medicare age but are receiving social security disability, once you have received the SSDI for 24 months, Medicare automatically becomes primary and you must be signed up for Medicare Parts A and B. This also goes for your dependent/domestic partner. If they have been on SSI for 24 months and you retire, Medicare is primary for them on the day of your retirement.

Again, Congratulations on behalf of NYSCOPBA's Retirement Department,

Bill Naylor x 257 & Paula Carlino x 245

New York State Correctional Officers & Police Benevolent Association, Inc.

www.nyscopba.org - retirement@nyscopba.org

Retiree Chapter (and Employees) Helpful Contacts

NYS Employees Retirement System
(Pensions, Calculations, COLA)
(518) 474-7736 or (866) 805-0990
110 State Street, Albany, NY 12244
Online Account- https://portal.osc.state.ny.us/
www.osc.state.ny.us

NYS Department of Civil Service
(Employee Health, Dental and Vision, Retiree Health & COBRA Vision & Dental)
(518) 457-5754 or (800) 833-4344
Fax (518) 485-5590
Employee Benefits Division
Albany, NY 12239
pio@cs.ny.gov
www.cs.state.ny.us

Empire Plan
PO Box 1600, Kingston, NY 12402
(877) 769-7447

GHI/EmblemHealth- Dental
(Employees Dental, COBRA, Direct pay for Retirees)
www.emblemhealth.com/
(800) 947-0101

Davis Vision- *(Employees Vision, COBRA, Chapter Discount Program)*
(800) 783-3594
www.davisvision.com

Social Security Administration
(Social Security, SS Disability)
(800) 772-1213
www.ssa.gov

Medicare
(800) 633-4227
(Federal Health insurance for 65 and older, Disabled)
www.medicare.gov

Norvest Financial– (*Life Insurance, Retiree Chapter Dental and Vision Discount Plan)*
(888) 869-8252
www.norvest.net

AFLAC
(Employees optional injury/illness ins.)
(800) 366-3436
www.aflacny.com

Liberty Mutual- Auto/Home
(Optional Auto/Home)
(800) 225-8281
www.libertymutual.com

MetLife – Auto/Home
(Optional Auto/Home)
877491-5087
www.metlife.com/mybenefits%20today

NYS Deferred Compensation
(800) 422-8463
www.nysdcp.com

AARP
(888) 687-2277
member@aarp.org - www.aarp.org

Retired Public Employees Association
(518) 869-2542 or (800) 726-7732
www.rpea.org

NYS Bar Association (*Attorney Referral)*
(800) 342-3661 - fax (518) 463-5993
lrs@nysba.org - www.nysba.org0

U.S. Department of Veteran Affairs
(800) 827-1000
www.va.gov

NYS Division of Veteran Affairs
(518) 474-6114 or (888) 838-7697
www.veterans.state.ny.us

Working Advantage *(Discounts for Employees and Retirees)*
800.565.3712
http://www.workingadvantage.com/
Click on "Register", "Employees", enter ID# 970929129. Flyer on our web site

NYS Retirement System Direct Dial Phone Numbers

Call Center	518.474.7736	Call Center	866.805.0990
Fax	518.402.4433	Arrears (reg # ending in 00 - 49)	518.474.4913
Arrears (reg # ending in 50 - 99)	518.474.8542	Arrears Payment	518.474.2987
Beneficiary Changes	518.474.3186	Deaths	518.474.7502
Deaths	518.474.6570	Disability	518.474.7736
Disability in Process	518.474.2078	Estimates	518.474.5369
Excess Contributions	518.474.7621	Loan Overpayments	518.474.7621
Loans	518.474.4608	Loan Information	518.474.7736
Membership Applications	518.474.3524	Retirement in Process	518.474.2608
Tier Reinstatement	518.474.1926	Tier Reinstatement	518.474.8482
Transfer of Membership	518.474.2602	Withdrawal	518.474.3502
Earnings Audit Section	518.474.4449	Pension Checks	518.474.4449
		Recalculations	518.486.5810
Pension payroll	518.474.5400	Pension service	518.474.7736

NYS Retirement System FAX Numbers

Service Retirement	518.402.2498	Member Documents	518.474.9438
Disability App. In Process	518.474.3091	Disability Retirees	518.408.3766
FOIL Requests	518.473.8940	General Fax	518.402.4433

NYS Retirement System Email Addresses & Web sites

Hearings	hearings@osc.state.ny.us	Secure Web Email Form	www.osc.state.ny.us/retire/index.php
Facebook	www.facebook.com/nyslrs	Blog	www.nyretirementnews.com
Twitter	www.twitter.com/nyslrs	Military Service Unit	msunit@osc.state.ny.us
General Email	nyslrsinfo@osc.state.ny.us	Matrimonial Bureau	dro@osc.state.ny.us

When contacting the NYS Retirement System *by phone, expect to spend considerable time on hold. Consider sending your questions with the Secure Web Email Form (best, web address above) or fax the number above (be sure to include your name, retirement number, your contact information your detailed questions and your social security number). Mail pension or other changes by certified, return receipt, to the New York State and Local Retirement System, 110 State Street, Albany, NY 12244-0001.*
When contacting NYS Civil Service *by phone, expect to spend considerable time on hold. Consider sending your general questions to pio@cs.ny.gov (be sure to include your name, retirement number, your contact information your detailed questions and your social security number). Mail health, dental, vision and COBRA changes certified, return receipt to the New York State Civil Service, Employee Benefits Division, Albany, NY 12239 (no street address is correct).*

New York State Correctional Officers & Police Benevolent Association, Inc.
102 Hackett Blvd., Albany, NY 12209
(518) 427-1551 nyscopba@nyscopba.org

Office Use Only

Retiree Chapter Membership Form

Send us this form upon your Retirement.
Update us with your Retirement Number at a later date.

Instructions on the back of this form

1) **Your Full Name (Last, First, MI) ***REQUIRED** **Last 4 SSN ***REQUIRED** **DOB *** REQUIRED** (__/__/____)

2) **PERSONAL INFORMATION**

Your Mailing Address

City **State** **ZIP**

Home Phone ( ) -
Cell Phone ( ) - ☐ *Check for text updates*
Facility you retired from

Email address

3) **SERVICE AWARD $10/YEAR AND OPTIONAL SERVICE PLAQUE- FILL OUT ONLY IF YOU ARE NEWLY RETIRED**

Seniority Date *(SSU Time Only)* __/__/____
Retirement Date __/__/____
# of Purchased Military Yrs.
☐ Send me a service plaque (Your service award of $10/year will be sent automatically)

4) **$20,000 LIFE INSURANCE BENEFICIARY DESIGNATION (FREE WITH CHAPTER MEMBERSHIP)**

Primary Beneficiary 1	**Relationship**	**Social Security #**	**% of Benefit**	Total % of all Primary beneficiaries must equal 100%
Primary Beneficiary 2	**Relationship**	**Social Security #**	**% of Benefit**	
Contingent Beneficiary 1	Relationship	**Social Security #**	% of Benefit	Total % of all Contingent beneficiaries must equal 100%
Contingent Beneficiary 2	Relationship	**Social Security #**	% of Benefit	

5) **RETIREMENT NUMBER (Update NYSCOPBA once you receive this number)** ____________

Prefix of 0S, 0O, 0A or 0B, followed by 7 digits OR prefix of R followed by 8 digits. You won't have a retirement number until the direct deposit of your pension begins (could be months after you retire). Update us when you get your retirement number so dues deduction can begin after your first free year.

6) **RETIREE CHAPTER DEDUCTION AUTHORIZATION TO THE COMPTROLLER OF THE STATE OF NEW YORK:** Pursuant to §110-b and §410-b of the Retirement and Social Security Law, I hereby authorize you to deduct $4.17 from my monthly retirement allowance as well as any deductions for insurance premiums from the New York State and Local Retirement Systems to cover membership dues payable on behalf of the New York State Correctional Officers and Police Benevolent Association, Inc. (NYSCOPBA) Retiree Chapter. This authorization is given to make any changes the union certifies to the Retirement System as necessary in the amount of such dues and insurance premiums. I understand that the NYSCOPBA Retiree Chapter is my agent and all requests to begin, modify, or revoke deductions must be submitted through the union. This authorization shall remain in effect until revoked by me by written notice through the union or until otherwise revoked pursuant to law. This authorizes you to make any adjustment deductions necessary for the purpose of payment of the annual dues and/or insurance premiums for all forms of insurance offered by NYSCOPBA. This is also your authorization to make deductions in succeeding years in the amount certified by NYSCOPBA as required for the payment of my membership dues and/or insurance premiums in said association.

7) **Signature to authorize beneficiaries and dues deduction (begins after first free year)** **Date**

You MUST sign up for dues deduction or your Membership will end after the first free year

Send this complete page to: **NYSCOPBA, Inc. Retirement Department, 102 Hackett Blvd., Albany, New York 12209**

Retiree Chapter Membership Form Instructions

This form can be used to sign up for the Chapter, renew membership, update your contact information, designate or change beneficiaries for the free life insurance policy and sign up for pension dues deduction. This form replaces all other forms for these purposes.

1) **Your Name, last four digits of your Social Security Number and date of birth-** These fields are required to validate your Membership with NYSCOPBA.

2) **Your personal contact information-** It is important that NYSCOPBA's Retirement Department be able to contact you. Please keep your contact information up to date.

3) **Service Award and optional Service Plaque-** NYSCOPBA provides a Service Award of $10 per year of service in the Security Services Unit. Fill in this section only if you are newly retired. Your Seniority date is the date you first started working in a Security Services Unit job title. If you purchased military time, fill in the number of years. If you want a personalized Service Plaque (at no cost to you), check the box.

4) **Beneficiary Designation-** NYSCOPBA Retiree Chapter members are entitled to a free $20,000 life insurance policy. In this section, you can designate beneficiaries for the policy. Use this section to designate or change beneficiaries at any time. Remember, Primary beneficiaries are paid first and if any Primary beneficiary is living, Contingent beneficiaries will not receive a benefit. Percentage of benefit for designated Primary beneficiary (or beneficiaries) must equal 100% and percentage of benefit for designated Contingent beneficiary (or beneficiaries) must equal 100%.

5) **Retirement Number-** Send us your form when you first retire. You will not have a retirement number at this time. You will receive your retirement number once you have been set up for direct deposit or your pension has been finalized. The Retirement System will mail you a letter establishing your new retirement number. Call and update us when you receive this new retirement number. Your retirement number has a prefix of 0S, 0O, 0A or 0B followed by seven digits OR prefix of R followed by 8 digits. If you cannot locate your retirement number, you will need to contact the Retirement System at (518) 474-7736 or (866) 805-0990.

6) **Dues Deduction Authorization-** Your first year in the Retiree Chapter is free. Pension dues deduction will begin at the end of your first free year. Once we process your dues deduction, it will be deducted from your monthly retirement check. Please note that dues deduction is required for Chapter membership after the first year.

7) **Signature and date-** You must sign and date this form. Any forms received without a signature and date will be returned to you.

If you need additional assistance, please feel free to contact us! http://www.nyscopba.org/retirement - retirement@nyscopba.org - 518.427.1551 - Bill Naylor x257 – Paula Carlino x245 - 518.426.1635 fax

How to Retire

This checklist will help guide you through the retirement process.

Step 1 **Request a general estimate** 12-18 months before you retire to determine the approximate amount of pension you can expect to receive monthly.

- ❑ **Form RS6030**.

Step 2

- ❑ After receiving your estimate from retirement, schedule an account checkup with deferred comp or meet with your financial advisor.

Step 3

- ❑ **Request a Retirement Packet from NYSCOPBA:**
  518-427-1551 ext. 225 or 257
  retirement@nyscopba.org

Step 4 **File for retirement** (All forms are in the NYSCOPBA Retirement packet.)
Submit the following applications to NYSLRS, 110 State St Albany, NY 12244-0001:

- ❑ **Form RS6037** - Application for Retirement, along with proof of your birth date, at least 15 but not more than 90 days prior to your date of retirement.
- ❑ **Form RS6399** - Options Election
- ❑ **Form RS6370** - Direct Deposit
- ❑ **Form W-4P** - Federal Withholdings. Use the OSC tax calculator to help you determine how much you should have withheld from your retirement benefit.

Step 5 Before your last day on the payroll, meet with your Health Benefits Administrator to:

- ❑ **File Form PS404**. Choose if you want to continue or defer your health insurance coverage as a retiree. You must decide no later than your last day on the payroll.
- ❑ **File Forms PS406.2** (Defer Health Ins. Coverage) and **PS410** (Sick Leave Credit Preservation) if you choose to defer. You must have other health insurance coverage, for example through your spouse's/domestic partner's employer or through post-retirement employment.
- ❑ **File Form PS405**. Choose if you want single or dual annuitant sick leave credit. You must decide no later than your last day on the payroll and if you choose it, you may not discontinue it later.
- ❑ **File Form RS6355** - Survivors Benefit Program.

Step 6

❑ **Return your Badge, Employees manual and uniforms on your last day on payroll.** At this time, your facility personnel office should ensure your health insurance forms are correct and submitted. They should also issue your retirement badge (if applicable).

Step 7

Choose if you wish to continue Dental or Vision coverage after retiring.

❑ **COBRA**: You have 60 days from the day you retire to sign up for COBRA dental or vision.

❑ Direct pay Emblemhealth: 60 days from retiring to enroll.

❑ NYSCOPBA Sponsored Dental or vision: 30 days from retiring to enroll.

Step 8

New York State Deferred Compensation Plan to:

❑ **Use up to $3,000 of your Deferred Comp to offset your health insurance costs.** Submit the Public Safety Officer Insurance Premium Payment Authorization Form and a copy of your first health insurance bill. to use up to $3,000 of your Deferred Comp to offset your health insurance costs.

❑ **Choose a payout option that fits your needs.**
NOTE: The earliest you can begin making withdrawals is 45 days following separation of service.

❑ **Decide when you want to take distributions.** The Plan does not require you to begin benefit payments until you are age 70 1/2, and separated from state service. After April 1 of the calendar year in which you reach age 70 1/2, the IRS requires you to take a minimum distribution or pay a penalty of 50% of the amount that was not withdrawn as required.

❑ **To begin receiving distributions:** Call the HELPLINE at 800-422-8463 and request a Benefit Distribution Packet. Confirm that your beneficiary information is up-to-date.

Step 9

❑ **Apply for Social Security.** Contact Social Security if you are 62 and plan to retire or if you are within three months of 65, even if you don't plan to retire.

❑ **Medicare**

- If you are receiving Social Security benefits for 24 months you will be sent Medicare information.
- If you are not receiving benefits, apply three months before your 65th birthday. Call Social Security to apply.
- As a retired NYS employee, you must enroll in both **Parts A & B ONLY** when you become eligible for Medicare. NYS will reimburse you for the cost of Part B.

The NYSCOPBA Retirement Department compiled this Checklist using information taken from the Work-Life Services Checklist. You may find this Checklist along with the 11 chapter Self-Help Guide to Pre-Retirement at www.worklife.ny.gov

Office of the New York State Comptroller
NYSLRS
New York State and Local Retirement System
110 State Street, Albany, New York 12244-0001

Please type or print clearly in blue or black ink

Received Date

Application for Service Retirement

RS 6037
(Rev.09/18)

NYSLRS ID

Social Security Number [last 4 digits]
XXX-XX-

Retirement System [check one]
Employees' Retirement System (ERS) ☐
Police and Fire' Retirement System (PFRS) ☐

Proof of your date of birth is require before a benefit can be paid. If it is not immediately available, file this application now and submit proof as soon as possible. The delay in filing this document will delay payment of your allowance.

THIS APPLICATION MUST BE ON FILE WITH THE RETIREMENT SYSTEM FOR AT LEAST 15 DAYS, BUT NO MORE THAN 90 DAYS, BEFORE YOUR RETIREMENT CAN BECOME EFFECTIVE.

Items 1-12 MUST be completed. The application must be signed and notarized on reverse side.

Information About You	
1. Name: (First, Middle Initial, Last)	**2. Date of Birth:**
3. Telephone Numbers: HOME ( ) CELL ( )	**4. Effective Retirement Date:****
5. Address: (Including Street, City, State and Zip Code)	

6. For United States Tax Withholding and Reporting Purposes: (please check one),
I am currently a: ☐ US Citizen ☐ Resident Alien ☐ Non-resident Alien

If you are a U.S. Citizen or Resident Alien:
This form will be used as a substitute IRS Form W-9. Under penalty or perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am writing for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from back withholdings; or (b) I have not been notified by the Internal Revenue Service (IRS) I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me I am no longer subject to backup withholding I am a U.S. Citizen/Resident Alien (defined in the instructions); and
3. I am a U.S. Citizen or other U.S. person (defined in the instructions) and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct (Note: This item does not apply for the Retirement application).

If you are a Non-resident Alien:
You must submit a W-8BEN tax form with your Retirement application. Please refer to the IRS instructions for directions to obtain this form. Retirement applications received without a W-8BEN tax form will be rejected. Federal Taxes must be withheld for Non- Resident Aliens.

* Social Security Number Required (see statement on reverse side)

** The effective retirement date is the first day of your retirement, not the last day worked. If you do not choose an *Effective Retirement Date*, we will, subject to your approval, establish the earliest possible retirement date.

7. Information About Your Public Employment:
To the best of your ability, please complete the following record of ALL PUBLIC EMPLOYMENT, including service in the ARMED FORCES. You may be able to secure credit for MILITARY SERVICE AND PUBLIC EMPLOYMENT, which previously may not have been available. Since you will not be able to claim any such service after your retirement becomes effective, you must provide information at this time.

Employer (Indicate whether State, County, City, Town, Village, etc.)	Department or Agency	Title of Position	Service From	Service To

8. Tier Reinstatement Application:
If you were previously a member of any public Retirement System in New York State you may be eligible to retire based on your previous membership date and tier. To apply for tier reinstatement, please complete this section.

IMPORTANT – You must complete other side

8. Tier Reinstatement Continued:

Former Membership Information: Please check the first Retirement System you were a member of:

- ☐ New York State Teachers' Retirement System
- ☐ New York State and Local Employees' Retirement System
- ☐ New York State and Local Police and Fire Retirement System
- ☐ New York City Employees' Retirement System
- ☐ New York City Board of Education Retirement System
- ☐ New York City Teachers' Retirement System
- ☐ New York Police Pension Fund
- ☐ New York City Fire Pension Fund

PLEASE COMPLETE THE FOLLOWING (if known):

Former Registration Number: _____ Date of Membership:_____

Former Name (if applicable): _____

Have you received credit for this former membership in any other retirement system? Yes ☐ No ☐

If Yes, what Retirement System? _____

Are you receiving or eligible to receive a retirement allowance based on this service? Yes ☐ No ☐

9. Other Public Retirement System Memberships:

- Are you **currently** a member of another public Retirement System in New York State? Yes ☐ No ☐
- Are you receiving or are you about to begin receiving a retirement benefit from any Retirement System on the basis of employment with New York State or any public entity in the State? Yes ☐ No ☐
- If yes, what Retirement System? _____ Registration Number: _____

10. Domestic Relations Order (DRO):

Retirement benefits are considered marital property and can be divided between you and your ex-spouse when the marriage ends in divorce. Any division of your benefits must be stated in the form of a Domestic Relations Order (DRO) – a legal document that gives us specific instructions on how your benefits should be divided.

- Do you have a current or pending legal restriction on the distribution of your pension benefit as a result of a DRO? Yes ☐ No ☐
- Have you ever been divorced? Yes ☐ No ☐

11. Beneficiary/Option Information for Estimate:

This is not the document on which you designate a beneficiary under your retirement option. You are require to make your option beneficiary on a separate form, called a "Retirement Option Election Form". If you have not filed a Retirement Option Election Form, we will be sending you one to complete and return. We are asking the following information about your intended beneficiary for informational purposes. It will ensure that the estimate, upon which you make your options selection, is based on the correct beneficiary. We are not permitted by law to accept untimely option election forms. If your form is not timely filed, the Law requires an option which does not provide benefits to any beneficiary.

Estimate Beneficiary Information:

Beneficiary Name	Date of Birth	Gender (M/F)	Spouse (Y/N)

Item numbers 12 and 13 **MUST** be completed or your application will not be accepted.

12. Please sign your name in full below: Women should sign their own names, e.g. Jane Smith **NOT** Mrs. John Smith

I certify that the information on my application is true and complete to the best of my knowledge. I further certify that I am aware that any false statement I knowingly make or permit to be made on this or any record of the Retirement System constitutes a crime punishable by potential incarceration and other sanctions.

I hereby make application for Service Retirement. I understand that this application may not be withdrawn on or after the effective date of retirement.

Signature:_____

13. Acknowledgement to be Completed by a Notary Public:

State of _____ County of _____ On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

NOTARY PUBLIC (Please sign and affix stamp)

POST RETIREMENT EMPLOYMENT: Your paid **public** employment must cease at the time of your retirement. There are laws governing employment after retirement, and if you plan to be employed by or contract with a **public** employer, it is important for you to know about them. Failure to comply with these laws could result in the suspension or diminishment of your retirement allowance or termination of your retirement and reinstatement in the Retirement System as a new member.

Public employment is employment by, or contract with, the State of New York, one of its political subdivisions (county, city, town village, school district) or some other public agency, such as a public authority. Employment by any other public employer located outside of New York State, employment by the Federal Government, or private employment, does not need any approval and will in no way affect the retirement allowance paid to you by this Retirement System. Any questions concerning this most important matter should be directed to the New York State and Local Retirement System. By signing this application I hereby elect coverage under Section 212 of the Retirement and Social Security Law, which permits me to earn from post-retirement public service annual amounts which do not exceed the limit provided in such section, without a resulting suspension or reduction of my retirement allowance.

HEALTH INSURANCE INFORMATION: The Retirement System does not administer Health Insurance Benefits. Any questions regarding this issue should be directed to your last employer.

***Social Security Disclosure Requirement:** In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Sections 11, 34, 311 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

Personal Privacy Protection Law: The Retirement System is required by law to maintain records to determine eligibility for and calculate benefits. Failure to provide information may interfere with the timely payment of benefits. The System may be required to provide certain information to participating employers. The official responsible for record maintenance is the Director of Member and Employer Services, NYS and Local Retirement System, Albany, NY 12244; call toll-free at 1-866-805-0990 or 518-474-7736 in the Albany Area.

Office of the New York State Comptroller

NYSLRS

New York State and Local Retirement System

110 State Street, Albany, New York 12244-0001

Please type or print clearly in blue or black ink

Received Date

Retirement Option Election Form

RS 6399

(Rev. 12/18)

NYSLRS ID

Social Security Number [last 4 digits] XXX-XX-

Retirement System [check one]

Employees' Retirement System (ERS) ☐

Police and Fire' Retirement System (PFRS) ☐

MAKE NO ALTERATIONS TO THIS FORM. Please review carefully the options available and the instructions provided.
You must:

1. Elect an option by checking the appropriate box (pages 1-2);
2. Sign and have the completed form notarized (page 2);
3. Return it promptly.

IMPORTANT: You must file your Option Election form before your pension benefit becomes payable, which is the first day of the month following your retirement. You have up to 30 days after the last day of your retirement month to change your option selection. If your election is not timely, by law, we must process your retirement as if you had selected the Single Life Allowance.

INFORMATION ABOUT YOU (Please make any needed corrections)	
1. Name: (First, Middle Initial, Last)	2. Date of Birth:
3. Address: (Including Street, City, State and Zip Code)	

TO THE COMPTROLLER OF THE STATE OF NEW YORK:		
Single Life Allowance	☐	I elect to receive the maximum lifetime retirement allowance payable to me. Stop all payments at my death. I understand that under this option I can not elect a beneficiary.
Joint Allowance – Full	☐	I elect to receive a reduced lifetime retirement allowance based on my life expectancy and the life expectancy of my beneficiary. If I die before my beneficiary, continue paying the same monthly amount to my beneficiary for life. If my beneficiary predeceases me, stop all payments at my death. I understand that I have up to 30 days after the last day of my retirement month to change my option or beneficiary.
Joint Allowance – Partial ☐ 25% ☐ 50% ☐ 75%	☐	I elect to receive a reduced lifetime retirement allowance based on my life expectancy and the life expectancy of my beneficiary. If I die before my beneficiary, continue a percentage of my retirement allowance to my beneficiary for life. If my beneficiary predeceases me, stop all payments at my death. I understand that I have up to 30 days after the last day of my retirement month to change my option or beneficiary. (If you take this option you **must also check** the percentage you wish to be continued to your beneficiary.)
Year Certain ☐ 5 Years ☐ 10 Years	☐	I elect to receive a reduced lifetime retirement allowance. If I die within my years selection after my retirement date, continue paying my retirement allowance for the remainder of the years to my beneficiary. If my beneficiary predeceases me, but I also die within my years following my retirement, continue payments for the rest of the period to another beneficiary I may name. If there is no surviving beneficiary, make a lump sum payment to my Estate. If I die more than my years selection after my retirement date, stop all payments at my death. (If you take this option, you **must also check** the years you wish to continued to the beneficiary.)
Pop-Up Joint Allowance-Full	☐	I elect to receive a reduced lifetime retirement allowance based on my life expectancy and the life expectancy of my beneficiary. If I die before my beneficiary, continue paying the same amount to my beneficiary for life. If my beneficiary predeceases me, change my allowance the Single Life Allowance (Option 0) amount and stop all payments at my death. I understand that I have up to 30 days after the last day of my retirement month to change my option or beneficiary.

IMPORTANT – You must complete other side

Pop-Up Joint Allowance- Partial ☐ 25% ☐ 50% ☐ 75%	☐ I elect to receive a reduced lifetime retirement allowance based on my life expectancy and the life expectancy of my beneficiary. If I die before my beneficiary, continue paying a percentage of my retirement allowance to my beneficiary for life. If my beneficiary predeceases me, change my allowance to the Single Life Allowance (Option 0) amount and stop all payments at my death. I understand that I have up to 30 days after the last day of my retirement month to change my option or beneficiary. (If you take this option, you **must also check** the percentage you wish to be continued to your beneficiary.)

If you elect the Single Life Allowance (Option 0) do not provide any beneficiary information.
If you wish to elect one of the other options, please read all of the information on this form and then complete the following section. Use the beneficiary's given name: Mary Smith, **NOT** Mrs. John Smith.
If you elect a Years Certain Option and wish to name more than one beneficiary, please let us know and we will provide you with an appropriate form.

INFORMATION ABOUT YOUR OPTION BENEFICIARY: (Please print plainly or type)		
Beneficiary's Name: (First Middle Initial, Last)	Beneficiary's Sex: ☐ M ☐ F	Beneficiary's Social Security Number:*
Beneficiary's Address: (Including Street, City, State and Zip Code)		
Beneficiary's Date of Birth:	Relationship of Beneficiary to you:	

*Social Security Number required (See statement below)

Please sign your name in full below:

I certify that the information on my application is true and complete to the best of my knowledge. I further certify that I am aware that any false statement I knowingly make or permit to be made on this or any record of the Retirement System constitutes a crime punishable by potential incarceration and other sanctions.

Retiree's Signature:_____ Date:_____

ACKNOWLEDGEMENT TO BE COMPLETED BY A NOTARY PUBLIC

State of _____ County of _____ On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

NOTARY PUBLIC (Please sign and affix stamp)

Electing An Option: The option you elect is important to both you and your beneficiary. Be sure you understand the nature of each option, and elect the one that best fulfills your needs. Also, be sure you have checked the proper box for the option that you wish to elect. On this form, you are selecting a method of payment. When you have completed this form and have had it notarized, the original should be returned to: **New York State and Local Retirement System**, 110 State Street, Albany, New York 12244-0001
We will acknowledge receipt of the option selection by sending you a letter.

Designating a Beneficiary: Only one beneficiary may be named in a Joint Allowance or Pop-Up option. Under these options, proof of your beneficiary's date of birth must be submitted. If you wish to elect one of the Year Certain Options, you may designate more than one beneficiary. If you wish to do so, please notify the Retirement System so we may send you the proper form for completion. If you elect one of the Year Certain Options, you may designate your Estate as beneficiary. Under these options, you may change your beneficiary at any time. For each change of beneficiary(ies), you must submit a form, which can be obtained from the Retirement System.

Information Services: Information Representatives are available at consultation sites throughout New York State. To find the one nearest you, visit our website at www.osc.state.ny.us/retire. You can also contact our Call Center toll-free at 1-866-805-0990 or 518-474-7736 in the Albany, New York area.

***Social Security Disclosure Requirement:** In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Sections 11, 34, 311 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

Personal Privacy Protection Law: The Retirement System is required by law to maintain records to determine eligibility for and calculate benefits. Failure to provide information may interfere with the timely payment of benefits. The System may be required to provide certain information to participating employers. The official responsible for record maintenance is the Director of Member and Employer Services, NYS and Local Retirement System, Albany, NY 12244; call toll-free at 1-866-805-0990 or 518-474-7736 in the Albany Area.

Office of the New York State Comptroller

NYSLRS

New York State and Local Retirement System

110 State Street, Albany, New York 12244-0001

Please type or print clearly in blue or black ink

Received Date

Electronic Funds Transfer Direct Deposit Enrollment Application

RS 6370

(Rev.12/19)

NYSLRS ID

Social Security Number [last 4 digits] XXX-XX-

Retirement System [check one]

Employees' Retirement System (ERS) ☐

Police and Fire' Retirement System (PFRS) ☐

See Reverse side for Information and Instructions

SECTION 1: TO BE REVIEWED AND CORRECTED BY PENSIONER:

Name: (First, Middle Initial, Last)	Preferred Telephone Number: (Please Provide)
Address: (Including Street, City, State and Zip Code)	Corrections: (If Any)

Please indicate the type(s) of payments you are receiving from this system:

Retiree ☐ Beneficiary of a retiree ☐ Alternate payee under a Domestic Relations Order ☐

Please ensure that you have checked the proper box or boxes for the funds that you wish to have deposited to this bank account. Note, if you do not select any of these boxes we will deposit all funds paid by us to this new EFT account.

SECTION 2: TO BE COMPLETED BY PENSIONER:

I hereby request all future benefits which become payable to me from the New York State and Local Retirement Systems (NYSLRS) be transferred to my account via Electronic Funds Transfer (EFT) Direct Deposit to:

Account Type: ☐ **Checking** (attach voided check to Section 3, or have Section 3 completed by your Financial Institution) **If your checks do not have your name imprinted on them, Section 3 MUST be completed by the Financial Institution.**

☐ **Savings- Section 3 MUST be completed by the Financial Institution.**

NYSLRS is authorized to continue making such benefit payments to said financial institution or any of its successors until NYSLRS receives written notice from me to the contrary. I agree that NYSLRS shall have no liability or responsibility for loss occasioned by erroneous information supplied by myself, my duly authorized representative or the financial institution.

I expressly acknowledge and understand any payments made pursuant to this request will be strictly an accommodation made to me by NYSLRS, and NYSLRS reserves the right to discontinue or decline to honor this EFT request without prior notice.

I hereby authorize and direct the financial institution, on my behalf, my joint account holder, if any, and my estate to charge my account for amounts paid to which I was not entitled. I also agree, on behalf of myself, my joint account holder, if any, and my estate, that such amounts will be returned to NYSLRS.

By making this request, I hereby represent the account identified herein (and as may later be modified) is not a trust.

Signature: _____ Date: _____

Signature of Joint Holder: (if any) _____ Date: _____

SECTION 3: TO BE COMPLETED BY YOUR FINANCIAL INSTITUTION IF DIRECTING FUNDS INTO A SAVINGS ACCOUNT OR IF A VOIDED CHECK IS NOT ATTACHED. THE ABOVE PENSIONER'S NAME MUST APPEAR ON THE ACCOUNT.

Name of Account: (Full Title of Account)
(Verify Account Type in Section 2 is correct)

Transit/ABA Number: (ACH Format-9 Digits)

Depositor's Account Number: (EFT Format – Cannot Exceed 17 Digits)

Name of Financial Institution: _____

Address: _____ Telephone Number: (_____) _____ - _____

City: _____ State: _____ Zip Code: _____ - _____

I, as a representative of the above named financial institution, agree to abide by the NACHA Rules and Regulations. Amounts paid to account holder to which he/she is not entitled will be returned to NYSLRS. Liability shall be limited as prescribed in the NACHA Rules and Regulations.

Bank Officer Signature: _____ **Bank Officer: (Please Print)** _____

PLEASE READ CAREFULLY

Enrollment Application:

NYSLRS provides direct deposit through the National Automated Clearing House Association (NACHA) Network which facilitates batch payment processing within the U.S. to domestic U.S. financial institutions. We do not transfer funds into international accounts across national borders.

NYSLRS will not make a direct deposit of a monthly pension payment into a trust account or any trust-like entity (i.e. Payable on Death Account). Section 110 of the Retirement and Social Security Law provides that the right of a person to a pension shall be unassignable. A trust, living or otherwise, is a separate legal entity that holds property or assets. Accordingly, the direct deposit of your pension benefit into a trust account would constitute an impermissible assignment under the law.

NYSLRS will not make direct deposit of a monthly pension payment to a pre-paid debit card. Since there is no personal bank account created and personally held by you when using a prepaid debit card, this too would be considered an impermissible assignment of benefits, not allowed by law.

The Electronic Funds Transfer Direct Deposit Enrollment Application must be signed by you and the joint account holder if any. Review Section 1 and make any necessary corrections and complete Section 2. If you are requesting direct deposit to a "Checking Account", attach a voided check to Section 3. If a voided check is not attached to Section 3, or if your checks do not have your name imprinted on them, then Section 3 must be completed by your financial institution. If requesting direct deposit to a "Savings Account", Section 3 must be completed by your financial institution. Return the application to NYSLRS.

Pensioner and Joint Account Holder Authorization for Recovery of Funds Deposited in Error:

By signing this Electronic Funds Transfer Direct Deposit Enrollment Application, both for yourself and your estate, and each joint account holder, if any, you consent to allow NYSLRS, through the designated financial institution, to debit your account in order to recover any NYSLRS benefits to which you were not entitled. This means of recovery shall not prevent NYSLRS from utilizing any other lawful means to retrieve NYSLRS benefit payments to which you were not entitled.

Changing Financial Institutions and/or Accounts:

You may change financial institutions and/or accounts by completing a new enrollment application. The new enrollment application, when processed, will cancel the enrollment at the previous financial institution or your prior account. You should, however, be aware that changing financial institutions and/or account could take up to **30 days to complete**. We recommend that the old account not be closed until the first deposit is made to your new account or financial institution.

Cancellation of Electronic Funds Transfer Direct Deposit:

To cancel this request, written notification from you must be received by NYSLRS at least 30 days prior to the next payment date.
The financial institution may terminate the electronic funds transfer direct deposit agreement with a written notice **30 days** in advance of the cancellation date. The financial institution cannot cancel the authorization without notification to both you and NYSLRS.

The New York State and Local Retirement System reserves the right to discontinue or cancel this electronic funds transfer direct deposit agreement at any time. Written notice will be provided to you.

The completed applications should be returned to the following address:

EFT/Pensioner Services
New York State and Local Retirement System
110 State Street
Albany, New York 12244-0001

Or you may fax the completed form and any attachments to (518) 473-5323.

Questions or problems should be directed to the address above or you may call us at (518) 474-7736 or toll free at 1-866-805-0990.

New York State Personal Privacy Law Notification:
The New York State and Local Retirement System (NYSLRS) requests personal information on this form to operate the NYSLRS/Electronic Funds Transfer Program. This information is being requested pursuant to State Finance Law 200(4) and Part 102 of Title 2 of the New York Codes, Rules and Regulations. The information will be provided to the designated financial institution(s) and/or their agent(s) for the purpose of processing payments, and for other official business of NYSLRS. No further disclosure of this information will be made unless such disclosure is authorized or required by law. A retiree's failure to provide the requested information may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program. The information provided will be maintained in NYSLRS under the direction of the Pensioner Services Section of the Benefit Calculation and Disbursement Services Bureau

New York State and Local Retirement System

Employees' Retirement System
Police and Fire Retirement System
110 State Street
Albany, New York 12244
http://www.osc.state.ny.us

Receipt Date

Office Use Only

FORM W-4P

WITHHOLDING CERTIFICATE FOR PENSION OR ANNUITY PAYMENTS
Tel No. 518-474-7736 in Albany area or Toll Free 1-866-805-0990
Fax No. 518-486-3252

PLEASE PRINT CLEARLY USING CAPITAL LETTERS, USE ONLY BLUE OR BLACK INK, STAY WITHIN BOXES. LEAVE BLANK BOXES BETWEEN WORDS AND NUMBERS

Social Security Number (Last 4 digits only) X X X - X X - _ _ _ _

Registration number (if known) _ _ _ _ _ _ _ - _

Last Name First Name M.I.

Street Address 1

Street Address 2

City State Zip Code

Complete **ONLY ONE SECTION**-Sign and date in the boxes below

Section 1

I **DO NOT** want to have Federal Income Tax withheld from my monthly benefit ☐

(**DO NOT** complete Section 2 or 3)

-OR-

Section 2

I want to have Federal Income Tax calculated and withheld using the Federal Tax Withholding Tables

Marital Status (check one) Single/Widow(er) ☐ Married ☐

Total number of allowances (exemptions) I wish to claim _ _ (example for 3 exemptions) 0 3

Please withhold an additional amount of $ _ _ , _ _ _ . _ _ each month.

(**DO NOT** complete Section 1 or 3)

-OR-

Section 3

I want to have a specific dollar amount of Federal Income tax withheld from my monthly benefit

Total Fixed Dollar Amount to be Withheld Monthly $ _ _ , _ _ _ . _ _

(**DO NOT** complete section 1 or 2)

Please send completed form to address above Attention Tax Unit Mail Drop 4-2

Signature:

Date

PERSONAL PRIVACY PROTECTION LAW

In accordance with the Personal Privacy Protection Law you are hereby advised that pursuant to the Retirement and Social Security Law, the Retirement System is required to maintain records. The records are necessary to determine eligibility for and to calculate benefits. Failure to provide information may result in the System's inability to pay benefits the way you prefer. The System may provide certain information to participating employers. The official responsible for maintaining these records is the Director of Member & Employer Services, New York State and Local Retirement Systems, Albany, NY12244. For questions concerning this form, please call 1-866-805-0990 or 518-474-7736.

SOCIAL SECURITY DISCLOSURE REQUIREMENT

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of the Social Security Account Number is mandatory pursuant to sections 11, 31, 34 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

New York State Correctional Officers & Police Benevolent Association, Inc.

102 Hackett Blvd., Albany, NY 12209
(518) 427-1551 www.nyscopba.org retirement@nyscopba.org

DENTAL BENEFIT OPTIONS UPON RETIREMENT

As an active employee, members receive dental coverage from the State. Upon retirement, members may continue coverage as follows:

1) **COBRA Coverage** ***(Recommended Coverage for new retirees, you can contact NYS Civil Service with questions at (800) 833-4344)***

Required to sign up through NYS Civil Service, **within 60 days of retirement**, **up to three years of coverage**, once cancelled you may not rejoin, **application will automatically be sent once Civil Service has been notified of your retirement.**

The dental care benefits you may continue are the same benefits you would receive as an active employee enrolled in the Emblem Health Preferred Dental Plan. There is also no change in benefits when your dependent enrolls in COBRA.

Who is eligible?

You- If you are an active employee enrolled in the Emblem Health Preferred Dental Plan, you have a right to continue coverage.

Your spouse or domestic partner- The spouse or domestic partner of an active employee covered as the employee's dependent by the Emblem Health Preferred Dental Plan, has the right to continue coverage under this plan. Legal separation (spouses only) your spouse does not automatically lose coverage if you are legally separated. However, if your spouse loses coverage under this plan, he or she may continue coverage under COBRA.

Dependent children- A dependent child of an employee covered by the Emblem Health Preferred Dental Plan has the right to continue coverage. Legal separation (Note: a dependent child does not automatically lose coverage because of parents' legal separation). A dependent child may be covered until the end of the month of their 19th birthday if not a full time student or until the end of the month of their 25th birthday if they are a full time student.

60-day deadline- Under COBRA, the employee or a family member is responsible for notifying the Employee Benefits Division of the New York State Department of Civil Service of a divorce or termination of a domestic partnership, a legal separation, social security determination that a qualified beneficiary was disabled at the time of employee's termination or reduction in hours, or if a child losing eligible dependent status under this Plan, within 60 days from the date of the qualifying event. Other people acting on your behalf may provide written notice to the Employee Benefits Division of a COBRA qualifying event. **If the enrollee or dependent does not notify the Employee Benefits Division in writing within that 60-day period, regardless of the reason, the dependent will not be entitled to choose continuation coverage.**

If you, your spouse/domestic partner or eligible dependent or someone acting on your behalf does not choose continuation coverage, your group dental insurance coverage will end.

How long you may keep COBRA coverage- You, the employee, will have the opportunity to maintain continuation coverage for 36 months or when you become Medicare eligible.

When you no longer qualify for COBRA coverage- If New York State no longer provides group dental care coverage to State employees; your 36 months of coverage has expired or If the premium for your COBRA coverage is not paid on time; If you become entitled to Medicare benefits during the COBRA continuation period.

Conversion rights after COBRA coverage ends- The COBRA law also requires that, at the end of the 36 month, you must be allowed to convert to a direct-pay conversion contract with Emblem Health.

If you choose COBRA coverage, you must exhaust those benefits before converting to a direct-pay conversion contract. If you choose COBRA coverage and fail to make the required payments or cancel coverage for any reason, you will not be eligible to convert to an individual policy.

Whom to contact- If you have any questions about COBRA, please contact NYS Civil Service Employee Benefits Division at (800) 833-4344.

Please note that the responsibility for determining your eligibility for continuation coverage under either COBRA or any state law rests solely with your employer, not with Emblem Health. Therefore, please do not contact Emblem Health about your eligibility for continuation coverage.

2) Direct Pay Policy (EmblemHealth) *(See flyer for coverage)*

Available only when you first retire or after completing three years of COBRA coverage. For individual contract with EmblemHealth, contact them for an application or if you have questions at (800) 947-0101)

Conversion Privileges- You may convert to one of Emblem Health's direct payment dental plans once your continuation coverage under COBRA terminates, unless the continuation coverage ends for one of the following reasons: You fail to make a premium payment for continued coverage within the specified time period; or, you cancel continuation coverage at any time for any reason.

EMBLEM HEALTH will send conversion information to your home.

Whom to contact- If you have any questions about conversion privileges, be sure to contact Emblem Health and/or NYS Civil Service Employee Benefits Division (800) 833-4344.

3) NYSCOPBA Retiree Dental Plan (EmblemHealth)

(See flyer for coverage, contact Norvest for rates at (888) 869-8252)

NYSCOPBA offers a dental plan through pension deduction for Retiree Chapter Members. Within this plan you have two options to choose from:

- ***Basic Dental Plan-*** Covers basic preventive services such as exams, cleaning, x-rays and sealants. You may sign up for the preventative plan at any time and you must remain in the plan until the following April 1st. Requires pension deduction of premiums.

- ***Enhanced Dental Plan-*** Includes all services covered by the Preventative Plan as well as basic and major care. Requires pension deduction of premiums and a 12 month commitment. The dental plans are administered by Norvest Financial Services and they can be reached at (888) 869-8252.

4) Dental $100 Reimbursement Plan

Free with Retiree Chapter Membership, administered by Norvest Financial Services at (888) 869-8252. Provides $100 reimbursement each year towards dental services purchased for Chapter Members only. Obtain a receipt showing Chapter Member as patient and out of pocket cost and submit receipt with reimbursement form to Norvest.

If you have questions or need an application, please call EmblemHealth at 800.947.0101

This option is available 1) when you first retire and 2) after 3 years of COBRA coverage

EmblemHealth®

55 Water Street, New York, New York 10041-8190

DIRECT PAY DENTAL POLICY

What Preferred Covers

The Preferred Dental Plan covers a range of dental benefits including preventive and diagnostic services, restorations, oral surgery, periodontics, periodontic surgical services, root canal therapy, dentures and bridgework.

The major advantages to the Preferred Dental Plan are:

- Access to a network of participating dentists. After you meet your annual deductible of $25.00 per person, we will pay a maximum benefit of $1,800 annually, per person, per calendar year.
- Reimbursement up to a schedule of allowances even when you use a non-participating dentist.
- No deductible for preventative and diagnostic services such as routine examinations, X-rays and cleanings.
- Dependent children under the age of 19 are eligible for dental coverage, including orthodontia up to a lifetime maximum of $1,000 when you elect a family plan.

Eligibility:

The Preferred Dental Plan is available to eligible New York State employees who leave New York State service and their covered dependents who lose eligibility and retirees of those participating employers that currently offer a New York State dental plan administered by the New York State Department of Civil Service. Your spouse and dependent children under the age of 19 are also eligible for coverage under this plan.

Provider Selection:

You may select any licensed dentist you wish for your dental care.

Participating Dentist:

After you meet an annual deductible of $25.00 per person, rendered by a participating dentist, the plan reimburses participating dentists and dental groups directly for covered services. We will reimburse 100 percent of the Preferred Schedule of Allowances for Preventive and Basic Services, 80 percent of this schedule for Major Services and 50 percent of this schedule for Orthodontics.

Non-Participating Dentist:

Non-Participating dentists do not have an agreement with us to limit fees. If you receive covered dental services from a non-participating dentist, you must pay the dentist directly. After you meet the annual deductible of $25.00 per person, we will then reimburse you at 100 percent of the Preferred Schedule of Allowances for Preventive and Basic Services, 80 percent of this schedule for Major Services and 50 percent of this schedule for Orthodontics, for covered services up to the annual maximum of $1,800.

Annual Maximum:

There is an annual maximum benefit of $1,800 per person.

Pre-Determination Amount:

If a course of treatment is expected to involve $300 or more of covered services, a description of the services along with an estimate of the dentist's charges must be filed with us before the course of treatment begins.

EMB_MB_OTH_22986_NYSDentalDirectPayRetiree 1/15

***Exclusions:**

Services rendered by other than a licensed dentist; procedures and appliances not required by accepted standard and dental practices, replacing lost appliances; services for which the patient incurs no dentist's charges, surgery for cosmetic purposes, treatment available under Worker's Compensation, Veteran's Administration, etc.; services from the dental or medical department of employer or similar group; any prosthetic appliance, fixed or removable, made as an adjunct to periodontal care, unless it replaces a missing tooth. No sealant coverage. *(Partial list of exclusions)

How to Enroll

If you are interested in enrolling in the Preferred Dental Plan, please fill out, sign, and return the completed application (enclosed with the information package). Upon receipt of your signed election form, we will process your request by sending you an invoice for the premium, which is billed quarterly. Upon receipt of your premium payment, you will be enrolled in the Preferred Dental Plan and new dental insurance identification card(s) will be mailed to you and your spouse (if applicable).

AnswerLine:

Retirees of New York State can also access the dedicated Dental Customer Service Center through our Dental AnswerLine, available toll-free 24 hours a day, seven days a week. This automated response system will provide instant answers to routine inquiries. In this way, enrollees will be able to contact us for assistance using the telephone number they already know.

Please call our dedicated Dental Customer Service Center at 1-800-947-0101 during the hours of 8am to 8 pm, Monday through Friday, with any questions.

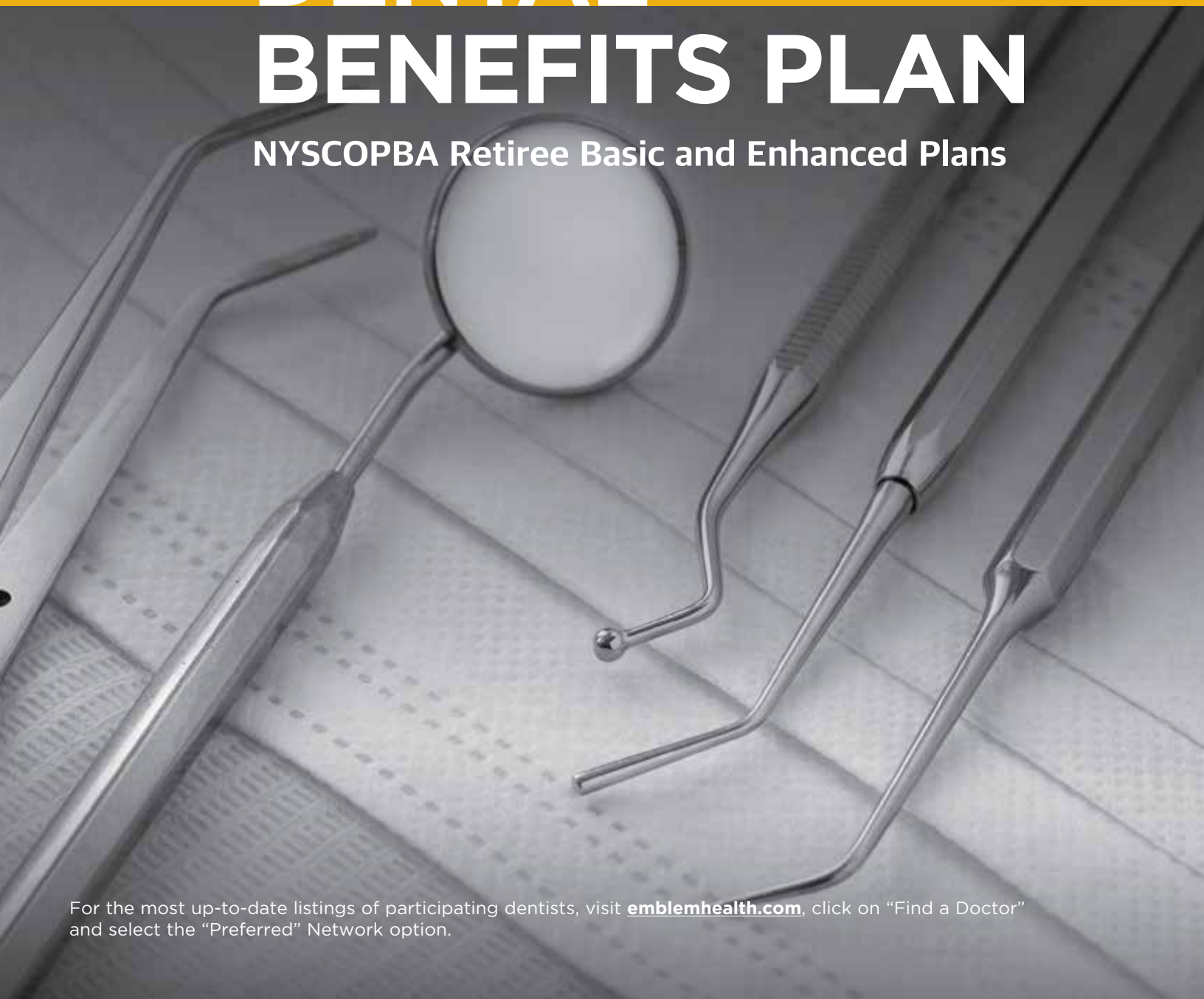
Benefits Outline

Preferred Plan Benefits Outline	
Annual Deductible	$25.00
Annual Maximum	$1,800
No deductible for Preventative & Diagnostic services	
Out-of-Network services are paid the same as In-Network services	
Provider Network: Approximately 7,000 provider locations	
Orthodontia Maximum $1,000 (separate from annual maximum)	$1,000

EmblemHealth®

PREFERRED DENTAL BENEFITS PLAN

NYSCOPBA Retiree Basic and Enhanced Plans



For the most up-to-date listings of participating dentists, visit **emblemhealth.com**, click on "Find a Doctor" and select the "Preferred" Network option.

This dental plan gives you quality coverage with access to over 7,000 dentists and specialists in New York and New Jersey. You can choose a network dentist or specialist for services covered under your plan. You don't have to pick a specific primary care dentist.

Dependent Coverage: With this dental plan, you can cover your children until the end of the year they turn 26. Children can be covered for orthodontic services until the end of the month they turn 19 (Orthodontic coverage is only offered under the Enhanced Plan).

Predetermination of Benefits: EmblemHealth can let you know, before you go to the dentist, what dental services and materials will be paid for before you go to your dentist. Ask your dentist to send a Treatment Plan to EmblemHealth before you get oral surgery, prosthetics or appliances. EmblemHealth will review the Treatment Plan and tell you and your dentist what is covered. Please note: If you are receiving any Type A or basic restorative services (shown in the table below), you do not need to get a Predetermination of Benefits.

Dental Services Not Covered:

- Cosmetic surgery and treatment unless it is reconstructive surgery caused by trauma, infection, or disease of the involved part.
- Prescription drugs and medicines.
- Services and appliances for the treatment of temporomandibular joint (TMJ) dysfunction.
- Transplantations

Major and Orthodontic services are not covered under the Basic Plan. Major and Orthodontic coverage is offered ONLY under the Enhanced Plan.

Basic Plan

Annual Maximum: $1,500
This is the maximum dollar amount your dental plan will pay toward the cost of dental care during your benefit period. You are personally responsible for paying costs above the annual maximum.

Enhanced Plan

Annual Deductible: $25 per individual, $75 family Type B and C services only. This is the amount you pay each year before your plan begins to pay.

Annual Maximum: $2,000
This is the maximum dollar amount your dental plan will pay toward the cost of dental care during your benefit period. You are personally responsible for paying costs above the annual maximum.

Lifetime Orthodontic Maximum: $1,000
This is the maximum dollar amount your dental plan will pay toward the cost of Orthodontic dental care until the end of the month your child turns 19. You are personally responsible for paying costs above the lifetime maximum.

	BASIC PLAN		ENHANCED PLAN	
BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Type A – Preventive and Diagnostic Services				
Base Coverage Level	**EmblemHealth will pay 100% of the bill when you see a Preferred Dentist or Specialist.**	**Your plan has agreed to pay a set dollar amount for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon dollar amount.**	**EmblemHealth will pay 100% of the bill when you see a Preferred Dentist or Specialist.**	**Your plan has agreed to pay a set dollar amount for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon dollar amount.**
Examinations – 2 periodic exams per each person on the plan per calendar year. 1 comprehensive examination per dentist, per lifetime.	Covered You don't have to pay for these services.	**Your plan has agreed to pay a set dollar amount for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon dollar amount.**	Covered You don't have to pay for these services.	**Your plan has agreed to pay a set dollar amount for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon dollar amount.**
Prophylaxes (Cleanings) – 2 per person per calendar year				
X-Rays – 4 bitewing x-rays per person on the plan per calendar year. • 1 full-mouth series of x-rays or 1 panoramic film per person on the plan once every 3 years.				
Fluoride Treatments – 1 per person on the plan per calendar year. Coverage provided until the end of the calendar year the child turns 19.				
Space Maintainers – 1 per each child on the plan per lifetime. Coverage provided until the end of calendar year the child turns 19.				
Athletic Mouth Guards – 1 per each child on the plan, per lifetime. Coverage provided until end of the calendar year the child turns 19.				

Continued on next page

NOTE: This is not a complete benefit comparison or a contract and should only be viewed as a brief summary to help you understand this EmblemHealth benefit program. A detailed benefits description, including limitations and exclusions, is contained within the Certificate of Insurance. The terms, conditions, limits and exclusions shown in the Certificate of Insurance shall govern. Additional In-Network Cost: You may need to pay additional costs for the use of upgraded materials. If a different benefit is used, you are responsible for the difference between the fee your dentist sends to EmblemHealth and the amount that EmblemHealth pays. You and your network dentist must agree in advance to treatment plans and payment methods for non-covered services.

	BASIC PLAN		ENHANCED PLAN	
BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Type B – Basic Services				
Base Coverage Level	**EmblemHealth will pay 80% of the agreed-upon dollar amount when you see a Preferred Dentist or Specialist. You are responsible for the rest of the bill.**	**Your plan has agreed to pay 80% of the agreed-upon dollar amount for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon dollar amount.**	**EmblemHealth will pay 100% of the bill when you see a Preferred Dentist or Specialist.**	**Your plan has agreed to pay a set dollar amount for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon dollar amount.**
Simple Extractions **Basic Restorations (Fillings)** • Posterior composite fillings on molars are reimbursed at the fee paid for amalgam (metal) fillings. If you or someone on your plan chooses composite restorations on molars, you are responsible for the difference between what EmblemHealth pays and what your dentist charges. Discuss these additional fees with your dentist when reviewing the treatment and payment plans. **Endodontics (Root canal therapy)** • Pulpotomy covered once per tooth, per lifetime. Not covered if root canal done on same tooth by same dentist within 3 months of the pulpotomy. **Periodontics (Treatment of diseases of the gum and jaw)** • 5 periodontal treatments per person on the plan per calendar year. • 1 type of periodontal surgery and/or 1 graft per quadrant. **Oral Surgery (Surgical removal of an erupted tooth)** • Your plan will pay for x-rays taken for surgery, local anesthesia, and post-operative care. • Your plan will pay for surgery on fractured jaws, impactions, lesions in and around the mouth, and reimplantations. • Some types of oral surgery may be covered under your medical plan, not this dental plan. **Anesthesia & IV Sedation** – Your plan will pay for general anesthesia and IV sedation for covered services. Charges for local anesthesia are included in the allowance for the dental procedure. No separate allowance for local anesthesia. Analgesia and monitoring devices will not be paid for by your plan. **Palliative Services (Relief of pain)** • 1 service per person on the plan, per calendar year. This is for emergencies only. **Repair of Appliances** • Replacement of broken teeth or clasps, recementation of inlays, crowns, bridges and space maintainers. Replacement of broken facings. **Tests and Laboratory Exams** – Biopsy and examination of oral tissue.	Covered You are responsible for 20% of the agreed-upon dollar amount for these services.	**Your plan has agreed to pay 80% of the bill for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon dollar amount.**	Covered You do not have to pay for these services.	**Your plan has agreed to pay a set dollar amount for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon dollar amount.**

Continued on back page

	BASIC PLAN		ENHANCED PLAN	
BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Type C – Major Services				
Base Coverage Level	Not Covered	Not Covered	**EmblemHealth will pay 100% of the bill when you see a Preferred Dentist or Specialist.**	**Your plan has agreed to pay a set dollar amount for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon dollar amount.**
Fixed and Removable Prosthetics – Both temporary and permanent dentures, full or partial, repair, and crowns over implants. **Major Restoration** – Includes crowns, related post and core procedures and inlays. • Your plan will pay for replacement or substitution of appliances only after 5 years have passed since appliance was inserted. • EmblemHealth reimburses crowns, single abutment crowns, and pontics other than porcelain fused to base metal at the allowance for predominantly base metal. If you or someone on your plan chooses crowns other than porcelain fused to base metal, you will be responsible for the differences between what EmblemHealth pays and what your dentist charges. Discuss these additional fees with your dentist when reviewing the treatment and payment plans. • Your plan will pay for crowns or pontics for attachment or clasp purposes only if tooth cannot be restored by fillings. • When a fixed bridge and partial denture are inserted in the same arch, your plan will only pay for the partial denture unless 5 years have passed since prior insertion of the fixed bridge or partial denture. • No separate allowance for temporary service or appliance. • Your plan will pay for posts only if there is evidence of root canal on the tooth. • Charges for cementation of crown/inlay are included in allowance for the crown/inlay. • Crowns over implants are paid based upon the allowance for a single crown, porcelain fused to predominantly base metal. You are responsible for the difference between the amount the dentist charges EmblemHealth and the amount EmblemHealth pays the dentist.	Not Covered	Not Covered	Covered You don't have to pay for these services.	**Your plan has agreed to pay a set dollar amount for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon dollar amount.**
Type D – Orthodontics				
Orthodontic Base Coverage Level This benefit is available until the end of the month your child turns 19. This does not include charges for missed appointments or additional cosmetic banding options. You will be responsible for these charges.	Not Covered	Not Covered	EmblemHealth will pay 50% of the agreed-upon dollar amount (up to the max benefit of $1,000) when you see a Preferred Dentist or Specialist. You are responsible for the rest of the bill.	**Your plan has agreed to pay 50% of the agreed dollar amount (up to the max benefit of $1,000) for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon amount.**

Refer to Policy Forms PLD-1104-C and PLD-1103-C

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

New York State Correctional Officers & Police Benevolent Association, Inc.

Retiree Dental Reimbursement Program
Reimbursement Claim Form for Chapter Members Only

The NYSCOPBA Retiree Dental Reimbursement Program allows an eligible NYSCOPBA Retiree Chapter Member reimbursement of up to $100 for paid dental services (excludes dental premiums) from a provider of your choice. The reimbursement is for the Retired Member only and will be based upon the original paid receipt. You have until March 31st to file a claim for the previous year.

Member Information

(PLEASE PRINT CLEARLY)

Member Name:_____ Date of Birth: _____
First Middle Initial Last

Mailing Address: _____
Street City State Zip

Phone:_____ Email: _____
Area Code

Provider Information

Name of Dental Provider:

Name:_____

Address:_____

City:_____ State: _____ Zip: _____ Phone Number: _____

IMPORTANT NOTE: The Members name must be listed on the original paid receipt and submitted with the claim form. Reimbursement will NOT be made unless the original receipt is attached.

Member/Employee

I hereby certify that the information provided is true and accurate and the receipt attached is the original copy for the expenditure for which I request reimbursement. **Additionally, I have read and understand the fraud statement on the back of this form.**

Member Signature: _____ Date: _____

MAIL YOUR COMPLETED CLAIM FORMS & ORIGNAL PAID RECEIPT TO:
Norvest Financial Services, Inc. | 930 Albany Shaker Rd. | Latham, NY 12110

For questions please call 1-888-869-8252

FRAUD STATEMENT

Any person who knowingly and with intent to defraud and deceive NYSCOPBA's Retiree Dental Reimbursement Program and submits an application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

In **Florida**, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an insurance application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In **New York**, applicants for Accident and Health Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Kentucky** and **Pennsylvania**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In **Tennessee,** state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

New York State Correctional Officers & Police Benevolent Association, Inc.

102 Hackett Blvd., Albany, NY 12209
(518) 427-1551 www.nyscopba.org nyscopba@nyscopba.org

VISION BENEFIT OPTIONS UPON RETIREMENT

As an active employee, members receive vision coverage from the State at no cost. Upon retirement members can continue vision care coverage as follows:

1) COBRA Coverage *(You can contact NYS Civil Service with questions at (800) 833-4344)*

Required to sign up through NYS Civil Service, **within 60 days from when Civil Service mails you the application**, **up to three years of coverage**, once cancelled you may not rejoin, , **application will automatically be sent once Civil Service has been notified of your retirement.**

When Coverage Ends- Vision Care benefits cease if you resign, retire, transfer to an ineligible negotiating unit or are terminated, your Vision Care coverage will end **28 days after the last day of the last payroll period worked.** You may have certain rights to continue coverage as explained below.

The Vision Care benefits you may continue are the same benefits you receive as an active employee. This section summarizes your rights and obligations under the continuation coverage provisions of the law. If your spouse or domestic partner is also covered under the Plan, they should take the time to read this carefully.

60 Day Deadline- In order for dependents to continue coverage under COBRA, the employee or a family member is responsible for notifying the Employee Benefits Division of the New York State Department of Civil Service in writing of a divorce or termination of domestic partnership, a legal separation or of a child's losing eligible dependent status under the NYS Vision Plan within 60 days from the date coverage ends due to one of those events. Other people acting on your behalf may provide written notice to the Employee Benefits Division of a COBRA qualifying event. **If notice is not received in writing within that 60-day period, regardless of the reason, the dependent will not be entitled to choose continuation coverage.**

How Long You May Keep COBRA Coverage- You, the employee, will have the opportunity to maintain continuation coverage for 36 months. Dependents who were covered at the time of your initial qualifying event, and newborns or newly adopted children added to your COBRA continuation coverage within 30 days of birth or final adoption during your period of COBRA coverage, are considered qualified beneficiaries with their own rights to continue COBRA coverage for up to 36 months in the event of a second qualifying event. Other dependents added to your COBRA coverage, such as a newly acquired spouse or child who returns to school full-time, do not have continuation rights apart from yours. Enrolled spouses/domestic partners and dependent children who lose eligibility due to a COBRA qualifying event have the opportunity to elect COBRA continuation coverage for up to 36 months.

Who Is Eligible For COBRA?

You- If you are an active employee enrolled in the NYS Vision Plan, you have the right to continue coverage.

Spouses or Domestic Partners- The spouse or domestic partner of an employee covered as the employee's dependent by this Plan has the right to continue coverage under this plan. Legal separation (spouses only) -- Your spouse does not automatically lose Vision Care coverage if you are legally separated. However, if your spouse loses coverage under this Plan, he or she may continue coverage under COBRA.

Dependent Children- A dependent child of a covered employee has the right to continue coverage if coverage under this plan. Your legal separation (NOTE: A dependent child does not automatically lose coverage because of parents' legal separation). A dependent child may be covered until the end of the month of their 19th birthday if not a full time student or until the end of the month of their 25th birthday if they are a full time student.

When You or Your Dependents No Longer Qualify for COBRA- If New York State no longer provides Vision Care coverage to State employees; your 36 months of coverage has expired; If the premium for your COBRA coverage is not paid on time; If you become entitled to Medicare benefits during the COBRA continuation period.

Whom to Contact- If you have any questions about COBRA, please contact NYS Civil Service Employee Benefits Division (800) 833-4344.

Consider Cancelling COBRA Vision Coverage When Benefits are No Longer available in COBRA Coverage Period- The vision benefit is generally available to children once a year and adults once every two years. For most members, there will come a time during COBRA vision coverage where you will continue to pay for COBRA vision coverage but you will not be able to receive any benefits again before the expiration of COBRA coverage. You may want to consider cancelling coverage at that time.

1) Retiree Chapter Vision Insurance from Davis Vision ***(Recommended Coverage for new retirees, you can contact Norvest with questions at (888) 869-8252)***

Optional insurance through payroll deduction administered by Norvest Financial Services at (888) 869-8252. This vision benefit is available to all participants once a year. This is a new plan and you sign up for the Vision Plan at the beginning of each year, coverage begins in May and you must keep the plan until the following May. You can also sign up if you have a qualifying event such as losing your current vision coverage or retiring.

2) Eyeglass and Contact Lens $100 member/ $50 dependent Reimbursement Plan

Free with Retiree Chapter Membership, administered by Norvest Financial Services at (888) 869-8252. Provides $100 reimbursement for Chapter Members and $50 for spouses, domestic partners and children to age 23 each year towards the cost of eyeglasses or contact lens purchase. Obtain a receipt showing Chapter Member as patient and out of pocket cost and submit receipt with reimbursement form to Norvest.

DavisVision™

davisvision.com | 1 (877) 923-2847, 9977

Retiree Vision Plan

Client code: 9977

Frequency

Exam: January 1
Lenses & lens upgrades: January 1
Frame: January 1
Contacts, evaluation & fitting: January 1

Sign up during open enrollment

For more details about the plan, visit davisvision.com/member and enter your Client Code or call 1 (877) 923-2847 and enter your Client Code when prompted.

Exams & Services

Eye Exam copay:
$0

Contacts evaluation, fitting & follow-up:

Conventional lens	Specialty lens
Covered in full	**$60 allowance plus 15% savings**[1]

Lenses

Lens copay:
$40

Frame

Allowance:

$170

+Additional 20% **off** any overage.[1]

or

The Exclusive Collection copay:

Fashion	Designer	Premier
Covered in full	**Covered in full**	**Covered in full**

Contacts[2] in lieu of glasses

Allowance:

$150

+Additional 15% **off** any overage.[1]

Using your client code

Log in using your client code (listed above) at davisvision.com/member to find a list of in-network providers near you and access your benefit information.

The Exclusive Collection

The Exclusive Collection of frames is available at nearly 9,000 locations across the U.S. Log in to browse frames, and find a Collection near you.

Free breakage warranty

Your glasses are covered with our FREE one-year breakage warranty. Some limitations apply.

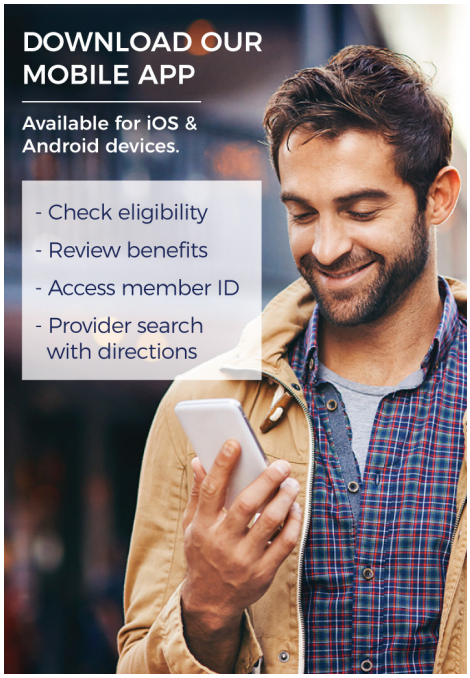
Find a network provider...

Enter your client code in the “Member Sign In” section of our website at davisvision.com/member to locate a provider near you including Visionworks.

Options & upgrades

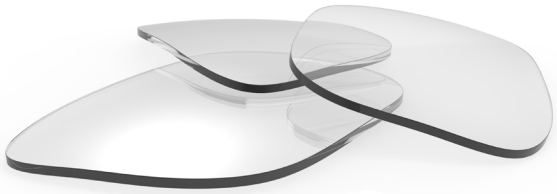
Lens options

Clear plastic single-vision, bifocal, trifocal or lenticular lenses (any RX)	$0
Polycarbonate Lenses (Children / Adults)	$0 or $30
High-Index Lenses 1.67	$0
High-Index Lenses 1.74	$120
Polarized Lenses	$75
Progressive Lenses (Standard / Premium / Ultra / Ultimate)	$0 / $40 / $90 / $125
Anti-Reflective (AR) Coating (Standard / Premium / Ultra / Ultimate)	$35 / $48 / $60 / $85
Ultraviolet Coating	$12
Tinting of Plastic Lenses (Solid / Gradient)	$0
Plastic Photochromic Lenses (Transitions® Signature™)	$65
Scratch-Resistant Coating	$0
Premium Scratch-Resistant Coating	$30
Scratch-Protection Plan (Single-Vision | Multifocal)	$20 | $40
Digital Single Vision Lenses	$30
Trivex Lenses	$50
Blue Light Filtering	$15



Additional savings

Retinal imaging (Member charge)	$39
Additional pairs of eyeglasses	30% discount[1]
Laser Vision Correction One-Time/Lifetime Allowance	$200



Employee rates	Monthly
Employee	$7.08
Employee + One	$19.23
Employee + Family	$27.32

Out-of-network benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network.

Out-of-network reimbursement schedule (up to)	
Eye Examination: $45	Trifocal Lenses: $65
Frame: $70	Lenticular Lenses: $100
Single-Vision Lenses: $30	Elective Contact Lenses: $120
Bifocal / Progressive Lenses: $50	Visually Required Contacts: $225

1. Some limitations apply to additional discounts; discounts not applicable at all in-network providers. 2. Contact lens coverage varies by product selection. Visually Required contacts are covered in full with prior approval. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.

New York State Correctional Officers & Police Benevolent Association, Inc.

Retiree Prescription Eyeglass and Contact Lens Reimbursement Program
Reimbursement Claim Form *for Chapter Members and Dependents*

The NYSCOPBA Retiree Prescription Eyeglass and Contact Lens Reimbursement Program allows an eligible NYSCOPBA **Retiree Chapter Member reimbursement of up to $100** for Members and **$50 for dependents** (spouse, domestic partner and child(ren) up to age 23) for paid prescription eyeglasses or contact lenses from a provider of your choice. The reimbursement will be based upon the original paid receipt. You have until March 31st to file a claim for the previous year.

Member Information

(PLEASE PRINT CLEARLY)

Member Name:_____ Date of Birth: _____
First Middle Initial Last

Mailing Address: _____
Street City State Zip

Phone:_____ Email: _____
Area Code

Patient Information

Patient Name: _____
First Middle Initial Last

Relationship: Member Spouse DOB:_____ Child DOB: _____ Reimbursement up to age 23 for Child

Provider Information

Name of Prescription Eyeglass or Contact Lens Provider:

Name:_____

Address:_____

City:_____ State: _____ Zip: _____ Phone Number: _____

IMPORTANT NOTE: The Members/Dependents name must be listed on the original paid receipt and submitted with the claim form. Reimbursement will NOT be made unless the original receipt is attached.

TOTAL REQUESTED REIMBURSEMENT: $_____

Member/Employee

I hereby certify that the information provided is true and accurate and the receipt attached is the original copy for the expenditure for which I request reimbursement. **Additionally, I have read and understand the fraud statement on the back of this form.**

Member Signature: _____ Date: _____

MAIL YOUR COMPLETED CLAIM FORMS & ORIGNAL PAID RECEIPT TO:
Norvest Financial Services, Inc. | 930 Albany Shaker Rd. | Latham, NY 12110
For questions please call 1-888-869-8252

FRAUD STATEMENT

Any person who knowingly and with intent to defraud and deceive NYSCOPBA's Retiree Prescription Eyeglass and Contact Lens Reimbursement Program and submits an application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

In **Florida**, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an insurance application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In **New York**, applicants for Accident and Health Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Kentucky** and **Pennsylvania**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In **Tennessee,** state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.