NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE BENEFITS DIVISION
NYSHIP Statement of Dependence
for "Other" Children
PS-457 (4/2020 L)

Enrollment or Recertification of an "Other" Child as a NYSHIP Dependent

This form must be completed when an enrollee applies for coverage on behalf of a dependent child who is other than the enrollee's natural-born or adopted child, stepchild, or the child of the enrollee's Domestic Partner. For such a dependent to be eligible, the child must: (1) reside permanently in the enrollee's home and (2) receive more than 50 percent of support from the enrollee. Support must have commenced before the child reached age 19. If you have a dependent who meets these criteria, please complete this form and submit it, the required proof of support along with a completed Health Insurance Transaction Form (PS-404 for NY and PE enrollees, PS-503 for PA enrollees).

EMPLOYEE INFORMATION			
1. Last Name First Name MI		**2.** Social Security Number	**3.** Date of Birth
4. Home Address Street City State Zip			**5.** Sex ☐ Male ☐ Female
6. Telephone Numbers Primary: ( ) Work: ( )		**7.** Agency Name: Code:	

"OTHER" CHILD INFORMATION		
1. Last Name First Name MI		
2. Social Security Number	**3.** Date of Birth	**4.** Sex ☐ Male ☐ Female
5. This application is for: ☐ Initial Enrollment **OR** ☐ Recertification		

ENROLLEE STATEMENT

☐ **I provide at least 50 percent of the dependent's financial support.**

If you are applying for initial enrollment or recertifying an "other" child who is **under the age of 19**, please attach one proof that documents your support.

Examples of an acceptable proof of financial support include:

- A copy of your current year's federal tax return claiming the "other" child as a dependent;
- A letter from a CPA, an enrolled agent, or an attorney stating that you can claim the dependent on your current federal tax return; or
- Proof of legal guardianship.

☐ **My home address on file is this dependent's permanent legal residence.**

If you are recertifying your "other" child who is **age 19 or older**, please attach one proof that shows the dependent's residence matches your permanent address on file. The proof submitted must have been issued within 6 months of the application date.

Examples of an acceptable proof of residence for the dependent include:

- Bank statement;
- Paycheck stub;
- Driver's license or automobile registration;
- Tax return (current year);
- Telephone or utility bill; or
- Student billing statement from an educational institution.

☐ **I anticipate that the dependent will reside with me for at least 2 years.**

If less than 2 years, when do you expect that the dependent will no longer reside with you? _____
mm/dd/yyyy

Personal Privacy Protection Law Notification

The information you provide on this application is requested in accordance with Section 163 of New York State Civil Service Law for the principal purpose of administering the New York State Health Insurance Program. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

I understand that any false or misleading statements made on this form will subject me to financial responsibility for any benefits paid on behalf of my 'other' child. I understand that false statements may result in disciplinary action by my employer and/or result in criminal and/or civil penalties as well as other legal actions including the prosecution of insurance fraud as defined in NYS Penal Law, Section 176.05; NYCRR, Title 11, Section 86.4 and U.S. Code, Title 18, Section 1035.

Print Enrollee Name: _____

Enrollee's Signature: _____ Date: _____
(Sign in the presence of notary)

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)

For Office Use Only	
☐ **Initial enrollment or recertification for an "other" child under the age of 19**	☐ Copy of the Dependent's Birth Certificate ☐ Proof of Support (50% or more) ☐ Health Insurance Transaction Form
☐ **Recertification of an "other" child who is age 19 or older**	☐ Copy of the Dependent's Birth Certificate ☐ Proof of Dependent's Residence ☐ Health Insurance Transaction Form
☐ Approved ☐ Not Approved	Date transaction submitted to add dependent: _____
HBA Signature: _____	Date: _____

THIS FORM MUST BE RETAINED BY THE EMPLOYING AGENCY WITH THE ENROLLEE'S ENROLLMENT RECORDS