NEW YORK STATE | **Department of Civil Service**
Employee Benefits Division

PS-457 (3/2025)

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

Department of Civil Service, Albany, NY 12239

INSTRUCTIONS: This form must be completed when an enrollee applies or recertifies 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 a dependent to be eligible, the child must: (1) have begun residing permanently in the enrollee's home before reaching age 19 and continue to do so, and (2) have begun receiving more than 50 percent of their support from the enrollee before reaching age 19 and continue to receive such support.

If you have a dependent who meets these criteria, please complete this form and submit it along with all required dependent proofs, including a birth certificate, proof of support and a completed *NYSHIP Health Insurance Transaction Form* (PS-404 for NY and PE enrollees, PS-503 for PA enrollees).

1–6 EMPLOYEE INFORMATION

1. Last Name | First Name | MI

2. Social Security Number _ _ _ – _ _ – _ _ _ _ | **3.** Date of Birth _ _ / _ _ / _ _ _ _

4. Home Address | Street | City | State | Zip

5. Telephone | Primary ( ) | Work ( )

6. Agency Name | Code

7–10 "OTHER" CHILD INFORMATION

7. Last Name | First Name | MI

8. Social Security Number _ _ _ – _ _ – _ _ _ _ | **9.** Date of Birth _ _ / _ _ / _ _ _ _

10. This application is for: ☐ Initial Enrollment **OR** ☐ Recertification

ENROLLEE STATEMENT

Check all the boxes below to confirm that each statement is true for your "other" child. You must also provide the necessary proofs listed on the instructions page. If applicable, enter the date and reason below.

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

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

☐ I anticipate that the dependent will reside with me for at least 2 years, unless:

- They will lose eligibility or obtain their own health coverage through employment during the next two years, or
- They are living away from home for college or in a dorm while my home remains their permanent address.

If you anticipate that the dependent will reside with you for less than 2 years, please specify when and why below.

Date: _ _ / _ _ / _ _ _ _

Reason: _____

_____

_____

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.

AUTHORIZATION

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)

Acknowledgment 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 (Required)** _____ **Date** _ _ / _ _ / _ _ _ _

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

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HOW TO FILL OUT THIS FORM

Complete this form fully, sign it, and have it notarized. You must also submit the necessary proofs to apply for or recertify coverage for your "other" child. Details about required proofs can be found in the **Enrollee Statement** section below.

EMPLOYEE INFORMATION

You must complete boxes 1–6 with your personal information.

"OTHER" CHILD INFORMATION

- You must complete boxes 7–9 with your "other" child's personal information.
- In box 10, indicate if this application is for an initial enrollment or a recertification.

ENROLLEE STATEMENT PROOF

Check the boxes in this section to confirm each statement applies to your "other" child, and refer to the table below for explanations of the required proofs and examples.

I provide at least 50 percent of the dependent's financial support.	If you are applying for initial enrollment of a child of any age 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 signed and completed copy of your federal tax return for the current tax year, claiming the "other" child as a dependent; • A letter from a licensed CPA (Certified Public Accountant) or an attorney, confirming that you can claim the dependent on your current federal tax return. **Letters from general tax preparers or tax preparation services are not acceptable.** • Proof of legal guardianship. This must be a court order. A notarized letter from a parent is not acceptable.
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.

AUTHORIZATION

Sign and date the form in the presence of a notary public. The notary must complete and stamp the form to validate your application.