



Enrollment Form

PSC-CUNY Welfare Fund
 25 Broadway, 15th Floor
 New York, NY 10004
 Office: 212-354-5230 www.pscunywf.org

Required A copy of your NYC Health Benefits Application is required and/or WF Domestic Partner form if Applicable.
 Dependent information will be obtained from your NYC Health Application unless you indicate otherwise.

Member	NYSUT ID: _____	NYS ID (State Colleges): _____
	Social Security: _____	Date of Birth: _____ / _____ / _____
	First Name: _____	Last Name: _____
	Address: _____	
	City: _____	State: _____ Zipcode: _____
	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> DP	Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U
	Primary Telephone: () _____	Primary Email: _____

Dental For more information visit: www.pscunywf.org

Guardian PPO

DeltaCare USA HMO *Delta will assign you a Dentist. To change it, call Delta or go Online.

Health Plan

_____	Basic	Rider	Waived	Stipend
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Waive ALL Benefits: Rx, Dental, Vision, Hearing Aid

Member I hereby certify that all of my personal information presented here is true and accurate.

 Signature Date

College	_____	Effective Date of Coverage: _____ / _____ / _____
	CUNY Campus _____	Effective Date of Hire: _____ / _____ / _____
	Job Title and Code _____	Earliest CUNY Hire Date: _____ / _____ / _____
	If Classified Managerial check here <input type="checkbox"/>	Previous College (if applicable) _____
	I hereby certify to the best of my knowledge that the information presented here is accurate, complete and sufficient to verify eligibility for benefits under the PSC-CUNY Welfare Fund.	
Benefits Officer _____	Date _____	

[PSC-CUNY Welfare Fund Use Only]	[Alpha]
Date Received	Authorization
Initials	Date