Enrollment Form

PSC-CUNY Welfare Fund
P.O. Box 280278
Brooklyn, NY 11228
Office: 212-354-5230 www.psccunywf.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: ☐ S ☐ M ☐ DP Gender: ☐ F ☐ M ☐ U

Primary Telephone: (___) _____ Primary Email: _____

Dental

For more information visit: www.psccunywf.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
_____	☐	☐	☐	☐

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 ☐ _____
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

Revised 9/2/22 RN