Enrollment Form

PSC-CUNY Welfare Fund

61 Broadway 15th Floor
New York, NY 10006

Enrollee

Social Security Number ______ - ______ - ______ **Job Title** ______________________

Last Name ______________________ **First Name** ______________________

Street Address ____

City ______________________ **State** ______ **Zip Code** ______

Office Telephone ( ) ______________ Home Telephone ( ) ______________

Date of Birth ____ / ____ / 19____ **Sex** ______ **Marital Status** ______

CUNY Campus

- Baruch College ☐
- Bronx Community College ☐
- Brooklyn College ☐
- Central Office ☐
- City College ☐
- Graduate Center ☐
- Hostos Community College ☐
- Hunter College ☐
- Hunter Campus School ☐
- John Jay College ☐
- Kingsborough Community College ☐
- LaGuardia Community College ☐
- Lehman College ☐
- Manhattan Community College ☐
- Medgar Evers College ☐
- NY City College of Technology ☐
- Queens College ☐
- Queensborough College ☐
- College of Staten Island ☐
- York College ☐

Educational Opportunity Centers

- EOC - Bronx ☐
- EOC - Brooklyn ☐
- EOC - Manhattan ☐
- EOC - Queens ☐

Health Insurance

	Basic	Rider
HIP-HMO	☐	
HIP-POS	☐	☐
GHI-CBP / Blue Cross	☐	☐
GHI HMO	☐	☐
Aetna HMO	☐	☐
Aetna QPOS	☐	☐
CIGNA Healthcare	☐	☐
Empire EPO	☐	☐
Empire HMO	☐	☐
Healthnet	☐	☐
Vytra	☐	☐
Waiver	☐	
Buy-out	☐	

Welfare Fund Dental Option

- Guardian ☐
- DeltaCare USA ☐

Effective Date of Hire ____ / ____ / ____

Earliest CUNY Hire Date ____ / ____ / ____

Previous College (if applcable) ______________

I hereby certify that all information I have provided on this Enrollment Form is true and accurate.

Member Signature ______________________

Date ______________

[PSC-CUNY Welfare Fund Use Only] ______________ Status ______________________ Authorization

FORM EF2007a

Covered Dependents

	Name	Male	Female	Social Security Number	Date of Birth
Spouse or Domestic Partner		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /

Dependent children must be under 19 years of age **or** be unmarried and be under 24 years old and be enrolled as a full-time student in a qualified institution of higher learning.
Sufficient documentation must be provided for each semester of school.

If your spouse or domestic partner is employed, you are required to disclose information on other health insurance. The PSC-CUNY Welfare Fund is your primary coverage for applicable benefits. If your spouse has comparable coverage, his or her carriers(s) are secondary for you. Dependent children are covered through standard coordination of benefit provisions.

Name of Spouse/Domestic Partners' Employer ______________________

Name of Insurance Coverage ______________________

Contact Phone Number for Spouse's Insurance ______________________

Coverage by Spouse's Insurance

- Hospital ☐
- Medical ☐
- Dental ☐
- Drug ☐
- Major Medical ☐
- Optical ☐
- Other ☐ ______________________

College HR Officer

The individual named herein is eligible for coverage effective / / 20

Signature	Position	Date

Change of Status Form

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Do Not use this Form to Notify of Change of Employer or Health Insurance or Title

Enter Name and Social Security Number as Currently Reported to the PSC Welfare Fund

Name ______________________ Social Security No. _____ - _____ - _____

Enter below only the information to be Changed :

☐ Name Change ______________________

☐ SSN Change ______________________

☐ Marital Status ______________________

☐ Address Change ______________________

____

☐ Add Dependent(s)

Name	Relationship	SSN	Date of Birth

☐ Drop Dependent(s)

Name	Relationship

☐ Other ______________________

College ______________________ Benefit Officer ______________________
Signature
Date ______________________

[PSC-CUNY Welfare Fund Use Only] ______________ ______________
Status Authorization

FORM CS2007