



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 _____

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

Covered Dependents

	<u>Name</u>	<u>Male</u>	<u>Female</u>	<u>Social Security Number</u>	<u>Date of Birth</u>
Spouse or Domestic Partner	_____	<input type="checkbox"/>	<input type="checkbox"/>	- - _____	/ / _____
Dependent Child	_____	<input type="checkbox"/>	<input type="checkbox"/>	- - _____	/ / _____
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Dependent Child	_____	<input type="checkbox"/>	<input type="checkbox"/>	- - _____	/ / _____

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 carrier(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

Check here if this enrollee is classified managerial

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

Signature

Position

Date