

# Adjunct Health Insurance Enrollment

PSC -CUNY Welfare Fund

61 Broadway, Suite 1500

New York, NY 10006

Semester \_\_\_\_\_ 20\_\_\_\_

|                              |                                 |   |  |
|------------------------------|---------------------------------|---|--|
| <b>Member</b>                |                                 |   |  |
| Last Name _____              | First Name _____                |   |  |
| Street Address _____         |                                 |   |  |
| City _____                   | State _____                     | Zip Code _____                                      |  |
| Social Security Number _____ |                                 |   |  |
| Marital Status:              | <input type="checkbox"/> Single | <input type="checkbox"/> Married / Domestic Partner | If you are married, you must provide information on your spouse, regardless of whether you elect family coverage |

|                                   |                                     |  |  |
|-----------------------------------|-------------------------------------|--|--|
| <b>Eligibility Qualifications</b> |                                     |  |  |
| College # 1                       | College Name _____ Department _____ | <input type="checkbox"/> Instructional | <input type="checkbox"/> Non-Instructional |
|                                   |                                     |  | Hours _____                                |
| College # 2                       | College Name _____ Department _____ | <input type="checkbox"/> Instructional | <input type="checkbox"/> Non-Instructional |
|                                   |                                     |  | Hours _____                                |

|                                 |   |  |
|---------------------------------|---|--|
| <b>Spouse Information</b>       |   | If you are married, you must provide information on your spouse, regardless of whether you elect family coverage |
| Legal Relationship              | <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner |  |
| Name _____                      | Social Security Number _____  |  |
| Spouse's Employer _____         |   |  |
| Spouse's Health Insurance _____ |   |  |

|                                    |   |  |               |
|------------------------------------|---|--|---------------|
| <b>Election of Coverage</b>        |   | Check ONE box Below. The <u>Quarterly</u> Premium is listed beside the option. |               |
|                                    | <u>Individual</u>                           |  | <u>Family</u> |
| <u>Metropolitan New York Area</u>  | <input type="checkbox"/> HIP Prime \$0      | <input type="checkbox"/> HIP Prime \$1,762.11                                  |               |
|                                    | <input type="checkbox"/> Blue Cross HMO \$0 | <input type="checkbox"/> Blue Cross HMO \$1,945.95                             |               |
| <u>Resident of NJ or CT</u>        | <input type="checkbox"/> Blue Cross HMO \$0 | <input type="checkbox"/> Blue Cross HMO \$1,945.95                             |               |
| <i>Outside Service Area --&gt;</i> | <input type="checkbox"/> Blue Cross EPO \$0 | <input type="checkbox"/> Blue Cross EPO \$2,862.60                             |               |
| <u>Mid-Hudson Service Area</u>     | <input type="checkbox"/> Blue Cross HMO \$0 | <input type="checkbox"/> Blue Cross HMO \$2,139.45                             |               |
| <u>Albany Service Area</u>         | <input type="checkbox"/> Blue Cross HMO \$0 | <input type="checkbox"/> Blue Cross HMO \$1,788.12                             |               |

I hereby certify that immediately prior to the current semester I have taught two or more consecutive semesters as an adjunct at CUNY or have been employed by CUNY in a non-instructional title with 10 or more hours per week in the previous two semesters. I further certify that I am not covered by nor eligible for other primary health insurance from any other source, including but not limited to other employment, my spouse's employment or governmental programs.

\_\_\_\_\_  
Member's Signature \_\_\_\_\_ Date

I hereby attest that two-semester requirement has been met in accordance with the rules of the PSC-CUNY Welfare Fund and that the hours and employment information is accurate for the semester indicated. The Fund shall be apprised of all relevant changes to the employee's schedule.

\_\_\_\_\_  
College Personnel Director College #1 Date

\_\_\_\_\_  
College Personnel Director College #2 Date