



# Enrollment Form

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

<b>Member</b>	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](http://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

<b>College</b>	_____	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