Retiree Enrollment Form

PSC-CUNY Welfare Fund
61 Broadway, 15th Floor
New York, NY 10006
Office: 212-354-5230 Fax: 212-354-5363
Website: www.psccunywf.org

Required

A copy of your NYC Health Benefits Application is required. WF Domestic Partner form if Applicable.

If Medicare Eligible, include a copy of your Medicare Card for you and/or your dependent.

If Member/Dependent is eligible for PSC-CUNY WF Med D Plan, include CVS SilverScripts Enrollment Forms.

Member

Retirement Date: ____/____/____ Pension ☐ TRS ☐ ERS ☐ TIAA

Social Security: _____ Medicare ID # _____ DOB: ____/____/____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Marital Status: ☐ S ☐ M ☐ DP Gender: ☐ F ☐ M

Primary Telephone: (____) _____ Primary Email: _____

Spouse Domestic Partner

Social Security: _____ Medicare ID # _____ DOB: ____/____/____

First Name: _____ Last Name: _____

Covered by other NYC Plan _____ *Welfare Fund* Covered by private Health Plan _____ *Name of Plan*

Dependents

SSN	Name	DOB	Gender	Status (child,disabled)

Dental

For previously Deferred Members Only. For more information visit: www.psccunywf.org

☐ Guardian ☐ *DeltaCare USA **Delta will assign you a Dentist. To change it, call Delta or go Online.*

Insurance

Health Plan _____ Basic ☐ Rider ☐ Waive All Benefits ☐

Member

I hereby certify that all of my personal information presented here is true and accurate.

Signature _____ Date _____

College

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 _____ College _____ Date _____

[PSC-CUNY Welfare Fund Use Only] [Alpha]

Date Received Authorization Initials Date