Retiree Enrollment Form

PSC-CUNY Welfare Fund
61 Broadway 15th Floor
New York, NY 10006

Member

Social Security Number ___ - ___ - ___ Date of Birth ___ / ___ / 19___

Last Name ___ First Name ___

Street Address ___

City ___ State ___ Zip Code ___

Marital Status ___ Sex ___ Home Telephone ( ) ___

Date of retirement ___ / ___ / ___ College ___

Spouse or Domestic Partner

☐ *Check if Domestic Partner*

Social Security Number ___ - ___ - ___ Date of Birth ___ / ___ / 19___

Last Name ___ First Name ___

Address if Different ___ Employer ___

Covered by other **NYC** Plan ___ (Welfare Fund Name) Covered by private health plan ___ (Name)

Eligible Children

Name	Date of Birth	Sex	Social Security Number	Status (if F/T student,Disabled,etc.)

Pension System

- ☐ TRS
- ☐ ERS
- ☐ TIAA

[/ /] Date Benefits Begun

Health Insurance

- ☐ GHI-CBP
- ☐ HIP
- ☐ Other ___
- ☐ Waived
- ☐ Deferred Until [/ /]

Medicare Coverage

Member	☐ Part A	☐ Part B
Spouse	☐ Part A	☐ Part B

If Medicare Coverage is indicated for member and/or spouse a photocopy of the Medicare Card(s) must be attached.

Please Notify the Fund Office if member or spouse enrolls in a Medicare Rx Plan (Part D).

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

___ (Retired Member) ___ (Date)

I hereby certify to the best of my knowledge that the information presented here is accurate and complete and sufficient to verify eligibility for benefits under the PSC-CUNY Welfare Fund.

___ (Benefits Officer) ___ (College) ___ (Date)