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 ______________ Covered by private Health Plan ______________

Welfare Fund *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 ☐

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 ______

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