



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*

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 _____ Date _____

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

Date Received _____ Authorization _____ Initials _____ Date _____