Adjunct Family Enrollment Supplement

PSC-CUNY Welfare Fund

61 Broadway, 15th Floor
New York, NY 10006
Phone (212) 354-5230
Fax (212) 354-5363

A copy of your NYC Health Beneftis Enrollment Form must be attached.

A copy of your PSCCUNY Welfare Fund Enrollment Form must be attached.

Enrollment in Family Coverage through NYC Health Benefits is Required

Enrollee

NY State / NY City ID #

Last Name

First Name

Social Security Number - -

	Name	Male	Female	Social Security Number	Date of Birth
Spouse / Domestic Partner				- -	/ /
Dependent Child				- -	/ /
Dependent Child				- -	/ /
Dependent Child				- -	/ /
Dependent Child				- -	/ /
Dependent Child				- -	/ /

I hereby certify that all information I have provided on this Enrollment Form is true and accurate.

I further agree to pay the posted premium for family coverage to the PSC-CUNY Welfare Fund

Effective Rate 10/1/2014 $202.00 / mo.

Member Signature _____ **Date** / /

[College HR Office Use Only]

The individual named herein is eligible for family coverage under the PSC-CUNY Welfare Fund and
All required documents have been presented to authorize coverage of individuals listed herein.

Signature | Name | Title/ Campus | / / Date Signed

[PSC-CUNY Welfare Fund Use Only]

Status | Authorization