



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 Benefits Enrollment Form must be attached.
A copy of your PSC-CUNY 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	____ - ____ - ____	

	<u>Name</u>	<u>Male</u>	<u>Female</u>	<u>Social Security Number</u>	<u>Date of Birth</u>
Spouse / Domestic Partner	_____	<input type="checkbox"/>	<input type="checkbox"/>	- -	/ /
Dependent Child	_____	<input type="checkbox"/>	<input type="checkbox"/>	- -	/ /
Dependent Child	_____	<input type="checkbox"/>	<input type="checkbox"/>	- -	/ /
Dependent Child	_____	<input type="checkbox"/>	<input type="checkbox"/>	- -	/ /
Dependent Child	_____	<input type="checkbox"/>	<input type="checkbox"/>	- -	/ /
Dependent Child	_____	<input type="checkbox"/>	<input type="checkbox"/>	- -	/ /

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 7/1/2016 \$190.75 / 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