



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 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	_____ - _____ - _____	

	<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