



Change of Status

PSC-CUNY Welfare Fund
 61 Broadway, 15th Floor
 New York, NY 10006
 Office: 212-354-5230 Fax: 212-354-5363
 Website: www.pscunywf.org

Required Include supporting documentation: marriage certificate, birth certificate and/or NYC Health Benefits application.
 If adding Domestic Partner include a WF Domestic Partner Enrollment Form

Member Enter Member Name, SSN as currently reported to the PSC CUNY Welfare Fund.

Social Security: _____ Date of Birth: _____
 First Name: _____ Last Name: _____

Type of Change

Name: _____
 Address: _____
 Health Plan: _____ Basic Rider Waived Stipend
 Marital Status: Domestic Partner Marriage Divorce Death of Spouse Date of Event ____ / ____ / ____
 Email: (H) _____ Email: (W) _____
 Tele: (H) _____ Tele: (W) _____

Only for Annual Dental Plan Changes Effective January 1.

DeltaCare USA HMO to Guardian PPO Guardian PPO to DeltaCare USA HMO
 ** Delta will assign you a Dentist. To change it, call Delta or go Online.

Other: _____

Change in Number of Dependents

Add Dependents

Name	Relationship	SSN	DOB	Reason

Drop Dependents

Drop RX

Drop Dental, Vision and Hearing

Drop All Benefits

Name	Relationship	Date of Event	Reason

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