

Enrollment Form



State
(to be completed by Delta)

New enrollment

Please return to:
PSC-CUNY Welfare Fund
61 Broadway - 15th Floor
New York, NY 10036
Tel: (212) 354-5230 Fax: (212) 354-5363

Delta Care USA

Member Social Security Number	Last Name	First Name	MI	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Address *(Is this a change of address?)* Yes No Street City State Zip Code

Group Number 2502	Group Name PSC - CUNY Welfare Fund
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DeltaCare USA Primary Care Dentist <i>(required for DeltaCare USA enrollees)</i>	DeltaCare USA Primary Dental Office ID No. <i>(required for DeltaCare USA enrollees)</i>
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Do you or your dependents have other dental coverage?
 Yes No *If yes, please complete the following:*

Carrier Name and Address: _____
Group Number: _____

Member Signature _____

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse			M F		
Children			M F		
			M F		
			M F		
			M F		
			M F		

Effective Date::	Sublocation::
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