



# Adjunct Enrollment Form

**PSC-CUNY Welfare Fund**  
 P.O. Box 280278  
 Brooklyn, NY 11228  
 Office: 212-354-5230 [www.pscunywf.org](http://www.pscunywf.org)

Required A copy of your NYC Health Benefits Application is required and/or WF Domestic Partner form if Applicable.  
 Dependent information will be obtained from your NYC Health Application unless you indicate otherwise.

Member	NYSUT ID: _____	NYS ID (State Colleges): _____
	Social Security : _____	Date of Birth: _____ / ____ / ____
	First Name: _____	Last Name: _____
	Address: _____	
	City: _____	State: _____ Zipcode: _____
	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> DP	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
	Primary Telephone: (   ) _____	Primary Email: _____

Dental	For more information visit: <a href="http://www.pscunywf.org">www.pscunywf.org</a> Guardian <input type="checkbox"/> DeltaCare USA <input type="checkbox"/> *Delta will assign you a Dentist. To change it, call Delta or go Online.	Health Plan	<u>Basic</u> <u>Rider</u> <u>Waived</u> <u>Stipend</u> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Member	I hereby certify that all of my personal information presented here is true and accurate.	
	Signature	Date

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.		
			Effective Date of Coverage: _____ / ____ / ____
			Effective Date of Hire: _____ / ____ / ____
			Earliest CUNY Hire Date: _____ / ____ / ____
	HR Signature - College 1	Print Name	Date
HR Signature - College 2	Print Name	Date	

[PSC-CUNY Welfare Fund Use Only]	[Alpha]
Date Received	Authorization
	Initials
	Date