Adjunct Family Enrollment Supplement

PSC-CUNY Welfare Fund

P.O. Box 280278
Brooklyn, NY 11228
Office: 212-354-5230 www.psccunywf.org

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 ____ - ____ - ____

	Name	Male	Female	Social Security Number	Date of Birth
Spouse / Domestic Partner		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /

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 ______________

Revised 9/6/22 RN

ENR FORM Eff. 7/2011