Retiree Enrollment Form

PSC-CUNY Welfare Fund
61 Broadway 15th Floor
New York, NY 10006

Member

Social Security Number ___ - ___ - ___ Date of Birth ___ / ___ / 19___

Last Name _____ First Name _____

Street Address _____

City _____ State ___ Zip Code _____

Marital Status _____ Sex ___ Home Telephone ( )

Date of retirement ___ / ___ / ___ College _____

Spouse or Domestic Partner

☐ *Check if Domestic Partner*

Social Security Number ___ - ___ - ___ Date of Birth ___ / ___ / 19___

Last Name _____ First Name _____

Address if Different _____ Employer _____

Covered by other **NYC** Plan _____ (Welfare Fund Name)

Covered by private health plan _____ (Name)

Eligible Children

Name	Date of Birth	Sex	Social Security Number	Status (if F/T student,Disabled,etc.)

Pension System

☐ TRS
☐ ERS
☐ TIAA

___ / ___ / ___
Benefit Start Date

Health Insurance

☐ GHI-CBP
☐ HIP
☐ Other _____
☐ Waived
☐ Deferred Until ___ / ___ / ___

Medicare Coverage

Member ☐ Part A ☐ Part B

Spouse ☐ Part A ☐ Part B

If Medicare Coverage is indicated for member and/or spouse a photocopy of the Medicare Card(s) must be attached.

Please Notify the Fund Office if member or spouse enrolls in a Medicare Rx Plan (Part D).

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

_____ (Retired Member) _____ (Date)

I hereby certify to the best of my knowledge that the information presented here is accurate and complete and sufficient to verify eligibility for benefits under the PSC-CUNY Welfare Fund.

_____ (Benefits Officer) _____ (College) _____ (Date)