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

[/ /] Date Benefits Begun

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