

# 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  Male  Female

Address (Is this a change of address?)  Yes  No \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Group Number **2502** Group Name **PSC - CUNY Welfare Fund**

DeltaCare USA Primary Care Dentist (required for DeltaCare USA enrollees) \_\_\_\_\_ DeltaCare USA Primary Dental Office ID No. (required for DeltaCare USA enrollees) \_\_\_\_\_

Do you or your dependents have other dental coverage?  
 Yes  No *If yes, please complete the following:*

Carrier Name and Address: \_\_\_\_\_

Member Signature \_\_\_\_\_ Group Number: \_\_\_\_\_

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: \_\_\_\_\_