

**Check all box(es) and complete all sections that apply.**

*If you are enrolling in Optional Disability Benefits, please complete the following information. When completed, return this form and the enclosed Payroll Deduction Authorization card, in the reply envelope provided, to PSC-CUNY Welfare Fund.*

*If this is a LATE enrollment, you will also need to complete a Medical History Statement and submit it directly to The Standard Life Insurance Company of New York.*

<b>APPLICANT</b>	Your Name (Last, First, Middle)		Group Name <b>The City University of New York</b>		Group Number/Campus <b>430209-A</b>	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation	
	Date of Hire	Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr			
<b>DISABILITY</b>	<i>For questions about the coverage options available to you, and any Evidence Of Insurability requirements, ask your HR Dept.</i> <b>Long Term Disability</b> <input checked="" type="checkbox"/> PSC-CUNY Welfare Fund – Paid LTD Basic Schedule <input type="checkbox"/> LTD Optional Schedule <input type="checkbox"/> MAPB					
	<b>CHANGE</b> <i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i> <input type="checkbox"/> Name Change      Former name _____ <input type="checkbox"/> Other _____					
<b>SIGNATURE</b>	I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.					
	Fraud Notice - Only applies to Accident and Health Insurance (AD&D/Disability/Dental): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.					
<b>TO BE COMPLETED BY EMPLOYER</b> Employee Signature Required _____ Date (Mo/Day/Yr) _____						
Group Number 430209		Effective Date of Insurance – Month/Day/Year				