

To Be Completed By Human Resources

Group Number 430209-A	Division	Billing Category	Date of Employment
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To Be Completed By Applicant Apply for Coverage Beneficiary Change *Complete Beneficiary Section below.* Name Change
 Add or Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Your Address		City	State	ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>			Phone Number	
Employer Name The City University of New York			Job Title/Occupation	
Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			

Coverage *Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements. If you are enrolling in Optional Long Term 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.*

Long Term Disability (LTD)

PSC-CUNY Welfare Fund – Paid LTD Basic Schedule

LTD Optional Schedule

LTD Optional Schedule (Includes Monthly Annuity Premium Benefit)

Signature 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.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____