Adjunct Family Enrollment Supplement

PSC-CUNY Welfare Fund

P.O. Box 280278
Brooklyn, NY 11228
Office: 212-354-5230 www.psccunywf.org

A copy of your NYC Health Benefits Enrollment Form must be attached.
A copy of your PSCCUNY Welfare Fund Enrollment Form must be attached.
Enrollment in Family Coverage through NYC Health Benefits is Required

Enrollee

NY State / NY City ID # _____

Last Name _____ **First Name** _____

Social Security Number - -

	Name	Male	Female	U	Social Security Number	Date of Birth
Spouse / Domestic Partner		☐	☐	☐	- -	/ /
Dependent Child		☐	☐	☐	- -	/ /
Dependent Child		☐	☐	☐	- -	/ /
Dependent Child		☐	☐	☐	- -	/ /
Dependent Child		☐	☐	☐	- -	/ /
Dependent Child		☐	☐	☐	- -	/ /

I hereby certify that all information I have provided on this Enrollment Form is true and accurate.
I further agree to pay the posted premium for family coverage to the PSC-CUNY Welfare Fund

Member Signature _____ **Date** _____

Effective Rate 1/1/2023

WF Benefits with Guardian Dental	**$ 218 per month**
WF Benefits with Delta Dental	**$ 143 per month**

[College HR Office Use Only]

The individual named herein is eligible for family coverage under the PSC-CUNY Welfare Fund and
All required documents have been presented to authorize coverage of individuals listed herein.

Signature	Name	Title/ Campus	Date Signed
			/ /

[PSC-CUNY Welfare Fund Use Only]

Status _____ Authorization _____