Change of Status

PSC-CUNY Welfare Fund
25 Broadway, 15th Floor
New York, NY 10004
Office: 212-354-5230 www.psccunywf.org

Required

Include supporting documentation: marriage certificate, birth certificate and/or NYC Health Benefits application.
If adding Domestic Partner include a WF Domestic Partner Enrollment Form

Member

Enter Member Name, SSN as currently reported to the PSC CUNY Welfare Fund.

Social Security: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Type of Change (Member Only)

☐ Name: _____

☐ Address: _____

☐ Health Plan: _____ ☐ Basic ☐ Rider ☐ Waived ☐ Stipend

☐ Marital Status: ☐ Domestic Partner ☐ Marriage ☐ Divorce ☐ Death of Spouse Date of Event ___/___/___

☐ Email: (H) _____ ☐ Email: (W) _____

☐ Tele: (H) _____ ☐ Tele: (W) _____

Only for Annual Dental Plan Changes Effective January 1.
☐ From DeltaCare USA HMO to Guardian PPO ☐ From Guardian PPO to DeltaCare USA HMO
** Delta will assign you a Dentist. To change it, call Delta or go Online.

☐ Other: _____

Change in Number of Dependents

⊕ Add Dependents

Name	Relationship	SSN	DOB	Reason

⊖ Drop Dependents

☐ Drop RX
☐ Drop Dental, Vison and Hearing
☐ Drop All Benefits

Name	Relationship	Date of Event	Reason

College

I hereby certify to the best of my knowledge that the information presented here is accurate, complete and sufficient to verify eligibility for benefits under the PSC-CUNY Welfare Fund.

Benefits Officer _____ Date _____

_____ _____
Member Signature Date