Change of Status

PSC-CUNY Welfare Fund
61 Broadway, 15th Floor
New York, NY 10006
Office: 212-354-5230 Fax: 212-354-5363
Website: 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

☐ 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.
☐ DeltaCare USA HMO to Guardian PPO ☐ 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

Employee Signature: ______________________ Date ______________________
I certify this information is accurate and sufficient to verify eligibility for benefits under the PSC-CUNY Welfare Fund.

Benefits Officer ______________________ Date ______________________

[PSC-CUNY Welfare Fund Use Only] [Alpha]

Date Received Authorization Initials Date