



# Change of Status

**PSC-CUNY Welfare Fund**  
 P.O. Box 280278  
 Brooklyn, NY 11228  
 Office: 212-354-5230 [www.pscunywf.org](http://www.pscunywf.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  
 Domestic Partner  Marriage  
 Marital Status:  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, Vision 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 \_\_\_\_\_

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

Date Received \_\_\_\_\_ Authorization \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_