Adjunct Health Insurance Enrollment

PSC-CUNY Welfare Fund

61 Broadway 15th Floor
New York NY 10006

Semester _____ 20____

Member

Last Name _____ **First Name** _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

Social Security Number _____

Marital Status: ☐ Single ☐ Married / Domestic Partner

If you are married, you must provide information on your spouse, regardless of whether you elect family coverage

Eligibility Qualifications

College # 1 _____ ☐ Instructional ☐ Non-Instructional _____ Hours
College Name Department

College # 2 _____ ☐ Instructional ☐ Non-Instructional _____ Hours
College Name Department

Spouse / Domestic Partner Information

If you are married, you must provide information on your spouse, regardless of whether you elect family coverage

Legal Relationship ☐ Spouse ☐ Domestic Partner

Name _____ Social Security Number _____

Spouse's Employer _____

Spouse's Health Insurance _____

Election of Coverage

Check ONE box Below. The Quarterly Premium is listed beside the option.

	Individual		Family	
Metropolitan New York Area	☐ HIP Prime	$0.00	☐ HIP Prime	$1,972.14
	☐ Blue Cross HMO	$0.00	☐ Blue Cross HMO	$2,528.25
Resident of NJ or CT	☐ Blue Cross HMO	$0.00	☐ Blue Cross HMO	$2,528.25
Outside Service Area -->	☐ Blue Cross EPO	$0.00	☐ Blue Cross EPO	$3,194.28
Mid-Hudson Service Area	☐ Blue Cross HMO	$0.00	☐ Blue Cross HMO	$2,775.60
Albany Service Area	☐ Blue Cross HMO	$0.00	☐ Blue Cross HMO	$2,326.32

I hereby certify that immediately prior to the current semester I have taught two or more consecutive semesters as an adjunct at CUNY or have been employed by CUNY in a non-instructional title with 10 or more hours per week in the previous two semesters. I further certify that I am not covered by nor eligible for other primary health insurance from any other source, including but not limited to other employment, my spouse's employment or governmental programs. Furthermore, it is my responsibility to contact the Welfare Fund if my hours fall below the required semester hours, as I will no longer be eligible for health insurance coverage and unless I elect COBRA, I will be responsible for all healthcare costs incurred.

_____ _____
Member's Signature Date

This Section Must be Completed PRIOR to Submitting to the PSC-CUNY Welfare Fund

I hereby attest that the two-semester requirement has been met in accordance with the rules of the PSC-CUNY Welfare Fund and that the hours and employment information is accurate for the semester indicated.
The Fund shall be apprised of all relevant changes to the employee's schedule.

College Personnel Director	College #1	Date
College Personnel Director	College #2	Date