



PSC-CUNY WELFARE FUND

28 West 44th Street, New York, NY 10036

(212) 354-5230

DATA SHEET (PLEASE TYPE OR PRINT)

TO BE RETURNED TO THE PSC-CUNY WELFARE FUND AT THE ABOVE ADDRESS

I. Name as on CUNY payroll

.....
Last Name

.....
First Name Initial

Social Security No.

If married name differs from that given above, please print your married name on the line below.

Married Name

If you have ever used another name on CUNY records please print it below.

.....

II. Address

.....
House Number and Street

.....
City State Zip Code

III. Home Telephone Number

(.....)
Area Code

Office Phone Number

IV. Sex Female Male

V. Date of Birth

.....
Month Day 19 Year

VI. Marital Status

Single Married

Widow(er) Divorced

Legally Separated

VII. Indicate NYC Health Insurance Coverage

GHI-CBP HIP/HMO GHI Type C Other

If Health Insurance has been Waived please check .

VIII. Rank (Please Check)

Professor Assoc. Assist.

Instructor Lecturer

Other

IX. Department

.....

X. Primary Current CUNY Affiliation.

1 Bernard M. Baruch College

2 Bronx Community Collegy

3 Brooklyn College.....

4 Central Office.....

5 City College.....

6 Graduate Studies Division 33 W. 42nd.....

7 Hostos Community College.....

8 Hunter College.....

9 John Jay College of Criminal Justice.....

10 Kingsborough Community College.....

11 LaGuardia Community College.....

12 Herbert H. Lehman College.....

13 Manhattan Community College

14 Medgar Evers College

15 New York City Community College.....

16 Queens College.....

17 Queensborough Community College

18 The College of Staten Island.....

19 York College

20 Educational Opportunity Center.....

(Indicate Unit)

XI. At which of the other units in X above, If any, have you had a full-time assignment;

Unit No. From To

XII. Date of Initial continuous Full-Time Employment at CUNY (In Covered Title)

.....

XIII. Current CUNY Annual Salary

Exclude Additional Salary earned in the Evening Session, Summer Session, Etc.

Effective Date..... 20

Amount \$.....

Signature

INSTRUCTIONAL STAFF MEMBER'S PAYROLL NAME

DEPENDENTS FOR PSC-CUNY WELFARE FUND HEALTH INSURANCE PURPOSES

A. Spouse Date of Marriage

Last Name First Name Social Security No.

Date of Birth, 20..... Relationship of Dependent to you—Wife Husband

Employed: Yes No Employer and Address:

B. Dependent Children (If unmarried between ages of 19-25 and a full-time student, please indicate college and expected date of graduation.) If not your natural child, indicate in each case whether adopted or stepchild and date.

Last Name First Name Social Security No.

Date of Birth, 20..... Relationship of Dependent to you—Son Daughter

Last Name First Name Social Security No.

Date of Birth, 20..... Relationship of Dependent to you—Son Daughter

Last Name First Name Social Security No.

Date of Birth, 20..... Relationship of Dependent to you—Son Daughter

Last Name First Name Social Security No.

Date of Birth, 20..... Relationship of Dependent to you—Son Daughter

Last Name First Name Social Security No.

Date of Birth, 20..... Relationship of Dependent to you—Son Daughter

Last Name First Name Social Security No.

Date of Birth, 20..... Relationship of Dependent to you—Son Daughter



SIGNATURE