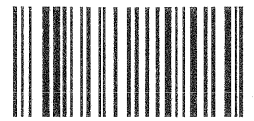


Patrolmen's Benevolent Association of the City of New York, Inc.

40 Fulton Street, New York, NY 10038
212 349-7560



PBA 6

ENROLLMENT FORM

I. MEMBER'S INFORMATION

NAME (LAST)		(FIRST)		(MIDDLE INITIAL)	
SOCIAL SECURITY NUMBER		DATE OF BIRTH MONTH DAY YEAR			
HOME ADDRESS NO. AND STREET					
CITY			STATE		ZIP CODE
PHONE NUMBERS HOME		WORK		CELL	
EMAIL ADDRESS *BY PROVIDING YOUR EMAIL ADDRESS, YOU MAY RECEIVE IMPORTANT INFORMATION AND NOTICES ABOUT YOUR BENEFITS BY EMAIL.					
GENDER (CIRCLE ONE) MALE FEMALE		MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED LEGALLY SEPARATED DOMESTIC PARTNER			
<input type="checkbox"/> ACTIVE WORK LOCATION	TAX REGISTRY NUMBER		<input type="checkbox"/> RETIRED RETIREMENT DATE _____		PENSION NUMBER (RETIREES ONLY)
POLICY, ID OR MEDICARE		IF MEDICARE, PART A - EFFECTIVE DATE / / IF MEDICARE, PART B - EFFECTIVE DATE / /			

II. SPOUSE/DOMESTIC PARTNER INFORMATION

NAME (LAST)		(FIRST)		(MIDDLE INITIAL)	
SOCIAL SECURITY NUMBER		DATE OF BIRTH / /		GENDER (CIRCLE ONE) MALE FEMALE	
IS YOUR SPOUSE/DOMESTIC PARTNER(CIRCLE ONE) EMPLOYED RETIRED NOT EMPLOYED EMPLOYED BY NYC AGENCY					
NAME AND ADDRESS OF SPOUSE/DOMESTIC PARTNER'S EMPLOYER					
DOES SPOUSE/DOMESTIC PARTNER HAVE NON-CITY GROUP HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF "YES" INDICATED NAME OF PLAN		POLICY <input type="checkbox"/> INDIVIDUAL EFFECTIVE DATE <input type="checkbox"/> FAMILY / /	
IS EMPLOYEE/RETIREE COVERED BY SPOUSE/DOMESTIC PARTNER GROUP HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		EFFECTIVE DATE / /		IF MEDICARE, PART A - EFFECTIVE DATE / / IF MEDICARE, PART B - EFFECTIVE DATE / /	

*MEMBER SIGNATURE REQUIRED ON BACK OF FORM.

III. DEPENDENT(S) INFORMATION

FIRST NAME	LAST NAME (if different)	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP TO MEMBER	GENDER M/F	ADD	DELETE	REASON

PLEASE NOTE: When adding or removing a dependent you must provide the applicable documentation, (e.g., birth certificate, marriage certificate or copy of divorce decree).

IV. REMARKS

V. I hereby state that the above information is correct and request the changes shown be made to my records. **I understand that these changes DO NOT alter my Life Insurance Beneficiary or my Basic Health Insurance records with the City of New York.**

DATE: _____ MEMBER'S SIGNATURE: _____

OFFICE USE ONLY

RECEIVED	ENTERED BY	VERIFIED BY	INFORMATION REQUESTED