Retiree Health and Welfare Fund

Patrolmen's Benevolent Association of the City of New York
125 Broad Street, 11th Floor, New York, NY 10004
Phone: (212) 349-7560 Fax: (212) 437-9480
www.nycpba.org

Dependent Enrollment Form – Retired Members

I. MEMBER'S INFORMATION

Name (Last)	**(First)**		**(Middle Initial)**
Social Security Number	**Date Of Birth** Month Day Year		
Home Address (House/Apt. # and Street Name)	**City**	**State**	**Zip Code**
Home Phone: **Cell Phone:** **Work Phone:**	**Email Address**		
Gender (check one) ☐ Male ☐ Female	**Marital Status (check one)** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Domestic Partner		
☐ **Currently Employed**	**Tax Registry Number**	☐ **Retired** **Retirement Date** ________ **Pension Number** ________	
☐ **Medicare (Part A) - Effective Date** / /		☐ **Medicare (Part B) -Effective Date** / /	

II. SPOUSE/DOMESTIC PARTNER/DEPENDENT(S) INFORMATION

Last Name	First Name	SS#	Date Of Birth	Relationship	Gender M/F	Disabled? YES/NO	Medicare Eligible?*	ADD/ DELETE?
Spouse/Domestic Partner							Yes No	ADD DELETE
Dependent							Yes No	ADD DELETE
Dependent							Yes No	ADD DELETE
Dependent							Yes No	ADD DELETE
Dependent							Yes No	ADD DELETE

*** If you circled Yes, please provide a copy of their Medicare card.**

III. OTHER INSURANCE INFORMATION

Do you, your spouse or any of your eligible dependents currently have any additional employer or government sponsored insured/self-insured health care coverage?

Yes ☐ ***No*** ☐

If you checked Yes, please complete the following section.

Policy Holder's Name	Relationship to Member	☐ Active ☐ Retired	Policy Holder's Date Of Birth
Effective Date of Coverage		Coverage Termination Date (if applicable)	
Coverage Provided ☐ Medical ☐ Prescription ☐ Dental ☐ Vision		Policy Type ☐ Single ☐ Employee + 1 ☐ Family	

Please list the name, date of birth, and relationship to the Member of those covered under the policy listed above.

Last Name	First Name	MI	Relationship to Member	Date of Birth

Please sign below and return this form to the:

PBA Funds Office
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New York, New York 10004
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By signing this form, I hereby certify that the information in sections I, II and III above is correct. I understand that if I provide incorrect information and that information results in the Fund making payments that it should not have made, I will be responsible for those payments.

Member's Signature ______________________________ **Date** ________________

For Office Use Only

RECEIVED	ENTERED BY	VERIFIED BY	INFORMATION REQUESTED