Retiree Welfare Fund

50 Broadway
11th Floor Suite 1101
New York, NY 10004
P: 212.532.7690
F: 212.481.4137
benefits@doctorscouncil.org
www.doctorscouncil.org

Please return the completed form by Email, Fax or Mail to the Doctors Council Retiree Welfare Fund. Also include, if applicable, copies of Birth and Adoption Certificates for all Children under the age of 26 and a copy of your Marriage Certificate or Domestic Partner Registration.

MEMBER INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #
ADDRESS Street	City	State	Zip

SEX F M	BIRTHDATE	RETIREMENT DATE	HOME PHONE	HOME FAX	CELL PHONE

EMAIL

SPOUSE AND DEPENDENT CHILDREN UNDER THE AGE OF 26

LAST NAME	FIRST NAME	MI	BIRTHDATE	RELATIONSHIP TO MEMBER

INSURANCE INFORMATION

Are you Eligible for Medicare? Yes No
If yes, are you covered by Medicare? Yes No Spouse? Yes No

Do you have City Health Plan Insurance? Yes No
If yes, which Plan do you have:
- GHI-CBP/Blue Cross with high option rider
- HIP/HMO with high option rider
- MED-PLAN with high option rider
- GHI Type C/Blue Cross with high option rider
- EMPIRE/HMO with high option rider

Are you a member of the NYC Employee's Retirement System? Yes No

If yes, Pension Number:

Do you have any other health insurance? Yes No
If yes, please specify

Does your spouse have any other health insurance? Yes No
If yes, please specify

MEMBER'S SIGNATURE	DATE