Retiree Welfare Fund

Doctors Council
National Office
50 Broadway, 23rd Floor
New York, NY 10004
Ph: 212.532.7690
Fax: 212.481.4137
info@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