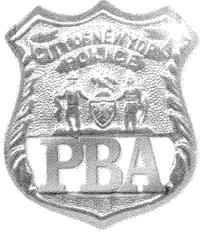
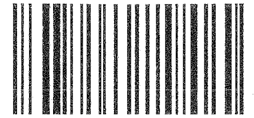


Patrolmen's Benevolent Association
of the City of New York, Inc.

125 Broad Street, New York, N.Y 10004
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

☐ ACTIVE WORK LOCATION ____________

TAX REGISTRY NUMBER

☐ 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?
☐ YES ☐ NO

IF "YES" INDICATED NAME OF PLAN

POLICY
☐ INDIVIDUAL
☐ FAMILY
EFFECTIVE DATE / /

IS EMPLOYEE/RETIREE COVERED BY SPOUSE/DOMESTIC PARTNER GROUP HEALTH PLAN?
☐ YES ☐ 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 hearby 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