



UFT WELFARE FUND,
52 BROADWAY, 7TH FLOOR, NEW YORK, NY 10004

**RIDER CLAIM FORM - 2007 BENEFIT YEAR
FOR NYC HEALTH INSURANCE PLANS**

Please sign and return the form with the appropriate documentation to the UFT Welfare Fund. If you carry the health plan, please complete only Section I and attach your pension stub to the completed form. Please complete both Section I and Section II if your spouse / domestic partner covers you under their city health plan and attach their City pension or payroll check stub.

SECTION I

Member's Full Name: _____ Telephone #: _____

Social Security Number or UFT Welfare Fund Alternate ID Number: _____

Current Address: _____

Are you a member of the Teachers' Retirement System (circle one)? YES NO

If no, which NYC pension system are you receiving your pension check from? _____

Pension # _____ Retirement Date: _____

Which NYC health plan are you enrolled in? _____

SECTION II (To be completed only when you are covered under your spouse / domestic partner's health plan)

Spouse's / Domestic Partner's Name: _____

Spouse's / Domestic Partner's Social Security Number: _____
(or WF alternate ID number if also a UFT member)

Is your spouse / domestic partner a member of the Teachers' Retirement System (circle one)? YES NO

If no, which NYC pension system is your spouse / domestic partner (if retired) receiving a pension check from?

Spouse's / Domestic Partner's Pension # _____ Retirement Date: _____

Which NYC Agency is your spouse / domestic partner currently working or retired from? _____

Member's Signature

Date