



PSC-CUNY WELFARE FUND

61 Broadway, 15th Floor, New York, NY 10006
(212) 354-5230 FAX (212) 354-5363

WEIGHT WATCHERS PARTICIPATION CLAIM FORM

You are covered for up to eight weeks of participation in a Weight Watchers program.
Please include receipts with this claim form and send to the Fund office at the address above.

Please print clearly and enter all information accurately. Any errors will delay the processing of your claim.

Member's Name: _____

Home Address: _____

Telephone: _____

Member's SS#: _____

Gender Female _____
 Male _____

College _____

I certify that I am eligible for this benefit.

Signature

Date

