

**CENTRAL INSURANCE PROGRAM (CIP) INDIVIDUAL ENROLLMENT FORM
 N.Y.C. MAYOR'S OFFICE OF OPERATIONS
 253 BROADWAY, 5TH FLOOR
 NEW YORK, NEW YORK 10007**

AGENCY NAME						
DYCD – CBO ID#		SUI#		EIN#		
ADDRESS			PHONE #			
EXECUTIVE DIRECTOR						
Employee Covered for Disability & Workers' Comp Insurance (As Appears in DYCD Approved Budget)						
SOCIAL SECURITY NUMBER	EMPLOYEE NAME LAST, FIRST		DATE OF BIRTH	DATE HIRED	FULL TIME PART TIME	DYCD BUDGET TITLE & TITLE CODE
	HOME ADDRESS		MALE FEMALE	YEARLY SALARY	WEEKLY HOURS	

Employee Signature/Date _____

Executive Director Signature/Date _____

Return Completed Form To: Department of Youth & Community Development
 156 William Street – 6th Floor
 New York, New York 10038
 ATT: Budget Review & Risk Management Unit