Universal Opt-Out/Drop Form

YOUR NAME AND EMPLOYEE NUMBER	Name Employee No.
CHECK ONE:	❑ **Full-time Active Employee:** Eligible for an annual payment of $1,500 from the Premium Conversion Plan instead of medical/vision and dental coverage under the Plan. ❑ **Part-time Active Employee:** Do not receive a payment from the Premium Conversion Plan. ❑ **Retirees:** Do not receive a payment from the Premium Conversion Plan. ❑ **New Service:** Eligible for an annual payment of $500 from the Premium Conversion Plan instead of medical coverage under the plan.

By signing this form, I understand that pursuant to the Washington Metropolitan Area Transit Authority Local 689 Premium Conversion Plan I may elect to receive an annual payment as noted above for my employment status instead of such medical/vision/dental coverage under the Plan. I further understand that by not electing the medical/vision/dental coverage, I will also not be obligated to make any contributions for that medical/vision/dental coverage to the Plan. I may still be required to pay for other coverages under the Plan.

I elect to receive the appropriate payment for my employment status as noted above and voluntarily waive my medical/vision/dental coverage under the Plan. I understand that by waiving my rights to the coverage, I am not entitled to medical/vision/dental benefits available through the Plan. I further understand that regardless of the reason that I wish to change this election, I will not be able to receive medical/vision/dental coverage under the Plan until January 1 immediately following the next Open Enrollment period.

❑ For **Part-time Employee:**
I now wish to terminate my coverage under the Transit Employees' Health & Welfare Plan effective____________.
I understand that I will not be able to join the Plan again until January of the following year.

❑ For **Retirees:**
I now wish to terminate my coverage under the Transit Employees' Health & Welfare Plan.

❑ For **Full-time Active Employees and New Service Agreement Employees:**
For my election and waiver to be effective, I understand that I must have alternative medical insurance.
I certify that I have medical coverage through:

Name of Insurance Company: ____________________
Policy Number and/or Group Number: ____________________
Telephone Number of Insurance Company: ____________________

This election and waiver will not be valid until the Health & Welfare office has confirmed your alternative insurance coverage.

Signature: ____________________ Date: ____________

Last 4 of SSN: ____________________ Employee's Telephone Number: ____________

Witness: ____________________ Date: ____________

Effective From January 1, 2022 to December 31, 2022

You must provide proof of other coverage.