FILL OUT THIS FORM **ONLY** IF…

- **you want to change your medical/vision and/or dental coverage AND**
- **you want to add or drop dependents**

Employee No. A

Daytime Phone: _____

I want to: ☐ **Add, remove or change dependents** ☐ **Change medical or dental plans**
☐ **Update life insurance beneficiary (Separate form required)**

Please make a selection from the chart below and return it to the Health & Welfare office.

Active Employees Open Enrollment Form

Name	Last Four Digits SSN
Spouse's Name	Spouse's SSN
Does your spouse work for Metro? Y N If yes, provide spouse's Employee Number_____	

I want to elect the following effective 1/1/2022:

Medical/Vision (including Prescription Drugs)	*Dental*	*Voluntary Benefits*
I want to change to:	*I want to change to:*	**Supplemental Life** Forms are available online at www.tehw.org or the Health & Welfare Fund office
Kaiser Permanente HMO and NVA Vision ☐ Single Coverage ☐ Family Coverage ☐ Spousal credit	**CareFirst** ☐ Single Coverage ☐ Family Coverage	
BlueChoice HMO and Davis Vision ☐ Single Coverage ☐ Family Coverage ☐ Spousal credit	**CareFirst with Ortho** ☐ Single Coverage ☐ Family Coverage	☐ **Opt-out** I understand that an opt-out is not final until the necessary documentation is porvided to the Health & Welfare Office *(See inside back cover)*
CareFirst BC Advantage Plan (POS) and Davis Vision ☐ Single Coverage ☐ Family Coverage ☐ Spousal credit	**CIGNA DMO** ☐ Single Coverage ☐ Family Coverage	☐ **Spousal Credit** **(Separate form required. Form available at Health & Welfare office or online at tehw.org)**

Enrollment Deadline: November 12, 2021

This form must be signed, placed in the enclosed envelope (postage required) then returned to the Health & Welfare office via mail or the mail slot at:

2701 Whitney Place, Suite 100
Forestville, MD 20747

IF YOU WANT TO ADD/DROP DEPENDENTS...

- **you must fill out the back of this form and provide it to the Health & Welfare office by November 12, 2021.**

Signature **Date**

If you remove a dependent, please indicate the address separately, so that we may send them a COBRA notice, if applicable. Dependents removed during open enrollment do not automatically qualify for COBRA coverage.

SPOUSE/DOMESTIC PARTNER* ☐ Add ☐ Remove	Employed by WMATA ☐ Yes ☐ No		
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F

Additional Info:

CHILD ☐ Add* ☐ Remove			
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F

Additional Info:

CHILD ☐ Add* ☐ Remove			
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F

Additional Info:

CHILD ☐ Add* ☐ Remove			
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F

Additional Info:

CHILD ☐ Add* ☐ Remove			
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F

Additional Info:

*Must Provide Documentation to Health & Welfare Office

(See page 4)

Signature ______________________________ Date ______________