

Universal Opt-Out/Drop Form

YOUR NAME AND EMPLOYEE NUMBER	Name _____ Employee No. _____
CHECK ONE:	<input type="checkbox"/> 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. <input type="checkbox"/> Part-time Active Employee: Do not receive a payment from the Premium Conversion Plan. <input type="checkbox"/> Retirees: Do not receive a payment from the Premium Conversion Plan and are not eligible to rejoin the Plan at any time. <input type="checkbox"/> 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 July 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 July 1 of the following year.

For Retirees:
I now wish to terminate my coverage under the Transit Employees' Health & Welfare Plan. I understand that I will not be able to rejoin the Plan at any time in the future.

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 non-METRO 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 non-METRO insurance coverage.

Print Employee's Name: _____ Employee Number: _____

Signature: _____ Date: _____

Employee's SSN: _____ Employee's Telephone Number: _____

Witness, H&W Staff: _____ Date: _____

Effective From _____ To _____

This form must be signed in the presence of a member of the H&W staff at the H&W office.