

## DO NOT FILL OUT THIS FORM IF...

- you want to **keep your same** medical/vision and dental coverage AND
- you **do not** want to add or drop dependents

Employee No. 

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Daytime Phone: \_\_\_\_\_

If you want to:  Add, remove or change dependents  Change medical or dental plans  
 Update life insurance beneficiary

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

## Active Employees Open Enrollment Form

Name	SSN
Spouse's Name	Spouse's SSN
Does your spouse work for Metro? Y N If yes, provide spouse's Employee Number _____	

Medical/Vision (including Prescription Drugs)		Dental		Voluntary Benefits
<i>I now have:</i>	<i>I want to change to:</i>	<i>I now have:</i>	<i>I want to change to:</i>	
<b>Kaiser Permanente HMO and NVA Vision</b> <input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage <input type="checkbox"/> Spousal credit	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>CareFirst</b> <input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage	<input type="checkbox"/> <input type="checkbox"/>	<b>Supplemental Life</b> Forms are available online at <a href="http://www.tehw.org">www.tehw.org</a> or the Health & Welfare Fund office
<b>BlueChoice HMO and Davis Vision</b> <input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage <input type="checkbox"/> Spousal credit	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>CareFirst with Ortho</b> <input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <b>Opt-out</b> I understand that an opt-out is not final until the necessary documentation is provided to the Health & Welfare office  (See p. 6)
<b>CareFirst PPO and Davis Vision<sup>1</sup></b> <input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage <input type="checkbox"/> Spousal credit	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>CIGNA DMO</b> <input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <b>Spousal Credit</b> I understand that the credit is not final until the necessary documentation is provided to the Health & Welfare office

<sup>1</sup> CareFirst PPO medical coverage is only available to employees hired before **March 1, 2013**. (Employees hired on or after March 1, 2013 are eligible to elect CareFirst PPO medical coverage after completing 39 months of service from the date of hire.)

## Enrollment Deadline: May 27, 2016

This form must be signed and returned to the Health & Welfare office at:

2701 Whitney Place, Suite 100  
 Forestville, MD 20747-3457

## 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 May 27, 2016. (See page 3 of this Enrollment Guide.)

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/DOMETIC PARTNER* <input type="checkbox"/> Add <input type="checkbox"/> Remove		Employed by WMATA <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name (Last, First, Mi)		Social Security	Date of Birth
			Sex <input type="checkbox"/> M <input type="checkbox"/> F

Additional Info:

CHILD <input type="checkbox"/> Add* <input type="checkbox"/> Remove			
Name (Last, First, Mi)		Social Security	Date of Birth
			Sex <input type="checkbox"/> M <input type="checkbox"/> F

Additional Info:

CHILD <input type="checkbox"/> Add* <input type="checkbox"/> Remove			
Name (Last, First, Mi)		Social Security	Date of Birth
			Sex <input type="checkbox"/> M <input type="checkbox"/> F

Additional Info:

CHILD <input type="checkbox"/> Add* <input type="checkbox"/> Remove			
Name (Last, First, Mi)		Social Security	Date of Birth
			Sex <input type="checkbox"/> M <input type="checkbox"/> F

Additional Info:

CHILD <input type="checkbox"/> Add* <input type="checkbox"/> Remove			
Name (Last, First, Mi)		Social Security	Date of Birth
			Sex <input type="checkbox"/> M <input type="checkbox"/> F

Additional Info:

**\*Must Provide Documentation to Health & Welfare Office**  
(See page 3)

Signature \_\_\_\_\_

Date \_\_\_\_\_