

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. **R**

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.

Retired 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 _____	

<i>Medical/Vision (including Prescription Drugs)</i>		<i>Dental</i>		<i>Voluntary Benefits</i>
<i>I now have:</i>	<i>I want to change to:</i>	<i>I now have:</i>	<i>I want to change to:</i>	
Kaiser Permanente HMO¹ and NVA Vision <input type="checkbox"/> Single Coverage <input type="checkbox"/> <input type="checkbox"/> Family Coverage <input type="checkbox"/> <input type="checkbox"/> Spousal Opt-Out <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Delta Dental <input type="checkbox"/> Single Coverage \$7.00 <input type="checkbox"/> <input type="checkbox"/> Family Coverage \$20.00 <input type="checkbox"/> <input type="checkbox"/> OPT OUT Dental Coverage <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Spousal Credit I understand that the credit is not final until the necessary documentation is provided to the Health & Welfare office
BlueChoice HMO and Davis Vision¹ <input type="checkbox"/> Single Coverage <input type="checkbox"/> <input type="checkbox"/> Family Coverage <input type="checkbox"/> <input type="checkbox"/> Spousal Opt-Out <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
CareFirst PPO and Davis Vision <input type="checkbox"/> Single Coverage <input type="checkbox"/> <input type="checkbox"/> Family Coverage <input type="checkbox"/> <input type="checkbox"/> Spousal Opt-Out <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

¹ Please see the Retired Employees Living Out of the Area section on page 15.

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

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 _____

Dependents removed from retiree coverage are not normally eligible for continued coverage under COBRA.

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
			<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
			<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
			<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
			<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
			<input type="checkbox"/> M <input type="checkbox"/> F

Additional Info:

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

Signature _____

Date _____