TRANSIT EMPLOYEES' HEALTH & WELFARE Plan Dependent Change Form

Full Time Regular ☐ Retiree ☐ Part Time ☐ New Service ☐

Employee Name ____ **Employee #** ____________

Address ____

Zip ____________ **Daytime Phone** ________________________ **SS#** ______/______/______

All dependent information must include the Social Security Number and an original birth certificate. Birth Certificates of children must list the member or the member's spouse as a parent.

I AM CURRENTLY ENROLLED/ OR ENROLLING IN THE BENEFIT PROGRAM LISTED BELOW

(CHECK ONE)

- **Kaiser Permanente** ☐ Single ☐ Family
- **BlueChoice** ☐ Single ☐ Family
- **CareFirst PPO** ☐ Single ☐ Family

(CHECK ONE)

- **CIGNA dental** ☐ Single ☐ Family
- **CareFirst dental** ☐ Single ☐ Family
- **CareFirst dental with Ortho** ☐ Single ☐ Family
- **Delta Dental** ☐ Single ☐ Family

If you are a BLUECHOICE ENROLLEE you must choose a primary care physician
If you remove a dependent, please indicate the address on the reverse side, so that we may send them a COBRA notice.

SPOUSE ☐ Add ☐ Remove	Employed by WMATA	☐ Yes ☐ No	
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
Name of Primary Care Physician		Physician Code #	
CHILD ☐ Add ☐ Remove			
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
Name of Primary Care Physician		Physician Code #	
CHILD ☐ Add ☐ Remove			
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
Name of Primary Care Physician		Physician Code #	
CHILD ☐ Add ☐ Remove			
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
Name of Primary Care Physician		Physician Code #	

Signature ______________________________ Date ____________

CHILD ☐ Add	☐ Remove		
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
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CHILD ☐ Add	☐ Remove		
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
Name of Primary Care Physician		Physician Code #	

Signature____ Date______________