CHILD SPOOT

Transit Employees'

HEALTH AND WELFARE PLAN

metro

2701 WHITNEY PLACE • FORESTVILLE, MARYLAND 20747
PHONE: (301) 568-2294 • FAX: (301) 568-7302

AMALGAMATED TRANSIT UNION LOCAL 689 AFL-CIO

Dear Member:

Our records indicate that you and your child are both eligible for coverage under the Transit Employees' Health & Welfare Fund Plan. Appendix B, Section H(5) of the agreement between the Washington Metropolitan Area Transit Authority (**WMATA**) and **Local 689** of the Amalgamated Transit Union AFL-CIO, effective May 1, 1995, states "if two or more employees of the same family are eligible for separate family coverage, their coverage shall be consolidated into **one** family plan." Therefore, in accordance with that agreement, you may enroll your child on your health plan.

By signing this form you consent to add/keep your dependent child on your health plan. At any time you or your child may void this agreement. In every case, the child is only eligible to stay on the parents plan until they would otherwise lose coverage – the end of the month in which they reach age 26.

Primary Member

Payroll #	Print Name	Signature

Child

Payroll #	Print Name	Signature

I _____ agree that _____

will be added to my coverage as a dependent effective _____.

_____

Signature **Date**

Please return the completed form to the Health and Welfare office in the enclosed self-addressed envelope. **If the form is not received by _____, the employee whose birth date comes first (month and day) will be designated to carry the family plan coverage.**

SPOOT

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Dear Member:

Our records indicate that you and your spouse, also a plan member, have dual coverage under the Transit Employees' Health and Welfare Plan. Appendix B, Section H(5) of the agreement between the Washington Metropolitan Area Transit Authority (**WMATA**) and **Local 689** of the Amalgamated Transit Union AFL-CIO, effective May 1, 1995, states "if two or more employees of the same family are eligible for separate family coverage, their coverage shall be consolidated into **one** family plan." Therefore, in accordance with that agreement, you must decide whether you or your spouse will carry the family plan coverage.

Primary Member

Payroll #	Print Name	Signature

Spouse

Payroll #	Print Name	Signature

I _____ agree that

_____ will be added to my coverage as a

dependent effective _____.

Date signed: _____

Please return the completed form to the Health and Welfare office in the enclosed self-addressed envelope. **If the form is not received by _____, the employee whose birth date comes first (month and day) will be designated to carry the family plan coverage.**