FILL OUT THIS FORM **ONLY** IF...

- you want to **change** your medical/vision and dental coverage AND
- you want to add or drop dependents

Employee No. R

Daytime Phone: _____

I 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	Last Four Digits 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 now have:	*I want to change to:*	*I now have:*	*I want to change to:*	
Kaiser Permanente HMO[1] and NVA Vision		**Delta Dental**		
☐ Single Coverage	☐	☐ Single Coverage $7.00	☐	
☐ Family Coverage	☐	☐ Family Coverage $20 .00	☐	
☐ Spousal Opt-Out	☐	☐ OPT OUT Dental Coverage	☐	☐ **Spousal Credit**
BlueChoice HMO and Davis Vison[1]				
☐ Single Coverage	☐			
☐ Family Coverage	☐			
☐ Spousal Opt-Out	☐			
CareFirst PPO and Davis Vision				
☐ Single Coverage	☐			
☐ Family Coverage	☐			
☐ Spousal Opt-Out	☐			

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

Enrollment Deadline: November 16, 2018

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 November 16, 2018. (See page 3 of this Enrollment Guide.)

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

SPOUSE/DOMESTIC PARTNER* ☐ Add ☐ Remove	Employed by WMATA ☐ Yes ☐ No		
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F

Additional Info:

CHILD ☐ Add* ☐ Remove			
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F

Additional Info:

CHILD ☐ Add* ☐ Remove			
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F

Additional Info:

CHILD ☐ Add* ☐ Remove			
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F

Additional Info:

CHILD ☐ Add* ☐ Remove			
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F

Additional Info:

*Must Provide Documentation to Health & Welfare Office

(See page 3)

Signature____ Date ________________