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

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

Employee No. A

Daytime Phone: _____

I want to: ☐ Add, remove or change dependents ☐ Change medical or dental plans
☐ Update life insurance beneficiary (Separate form required)

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

Active 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 _____

I want to elect the following effective 1/1/2020:

Medical/Vision (including Prescription Drugs)	*Dental*	*Voluntary Benefits*
I want to change to:	*I want to change to:*	**Supplemental Life** Forms are available online at www.tehw.org or the Health & Welfare Fund office
Kaiser Permanente HMO and NVA Vision ☐ Single Coverage ☐ Family Coverage ☐ Spousal credit	**CareFirst** ☐ Single Coverage ☐ Family Coverage	
BlueChoice HMO and Davis Vison ☐ Single Coverage ☐ Family Coverage ☐ Spousal credit	**CareFirst with Ortho** ☐ Single Coverage ☐ Family Coverage	☐ **Opt-out** I understand that an opt-out is not final until the necessary documentation is provided to the Health & Welfare office *(See p. 7)*
CareFirst PPO and Davis Vision[1] ☐ Single Coverage ☐ Family Coverage ☐ Spousal credit	**CIGNA DMO** ☐ Single Coverage ☐ Family Coverage	☐ **Spousal Credit** **(Separate form required. Form available at Health & Welfare office or online at tehw.org)**

1 CareFirst PPO medical coverage is only available to employees hired before **October 1, 2016**. (Employees hired on or after October 1, 2016 are eligible to elect CareFirst PPO medical coverage after completing 39 months of service from the date of hire.)

Enrollment Deadline: November 22, 2019

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 November 22, 2019. (See page 4 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/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 4)

Signature ______________________________ Date ____________