Transit Employees'
HEALTH AND WELFARE PLAN
metro
2701 WHITNEY PLACE • SUITE 100 • FORESTVILLE, MARYLAND 20747-3457
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TRANSIT EMPLOYEES LOCAL 689 HEALTH BENEFIT ENROLLMENT

Employee Name: _____ **Employee #:** _____

Date of Birth: _____ **SSN:** _____ **Gender:** ☐ Male ☐ Female

Address: _____

Cell or Home: _____ Email: _____

Spouse's Name if working for WMATA: _____ Employee #: _____

MEDICAL/DENTAL ENROLLMENT *(Please check one)*

You must provide copies of original birth certificates for children, proof of marriage and SSN for all dependents on this form

BlueChoice HMO Medical with CIGNA DMO Dental	☐ Single	☐ Family
BlueChoice HMO Medical with CareFirst PPO Dental	☐ Single	☐ Family
BlueChoice HMO Medical with CareFirst PPO Dental and Ortho	☐ Single	☐ Family
Kaiser Permanente HMO Medical with CIGNA DMO Dental	☐ Single	☐ Family
Kaiser Permanente HMO Medical with CareFirst PPO Dental	☐ Single	☐ Family
Kaiser Permanente HMO Medical with CareFirst PPO Dental and Ortho	☐ Single	☐ Family
BlueChoice Advantage POS Medical with CIGNA DMO Dental	☐ Single	☐ Family
BlueChoice Advantage POS Medical with CareFirst PPO Dental	☐ Single	☐ Family
BlueChoice Advantage POS Medical with CareFirst PPO Dental and Ortho	☐ Single	☐ Family

☐ I wish to Opt-Out of coverage. ***(You must complete an Opt-Out form and provide proof of other coverage to avoid being enrolled in the default coverage)***

	Name (Last, First, MI)	Social Security #	Date of Birth	Gender
Spouse				☐ M ☐ F
Child				☐ M ☐ F
Child				☐ M ☐ F
Child				☐ M ☐ F
Child				☐ M ☐ F

Signature _____ **Date** _____