TRANSIT EMPLOYEES' HEALTH AND WELFARE PLAN
2701 Whitney Place #100
Forestville, Maryland 20747
P: 301-568-2294 F: 240-745-3956 E: INFO@TEHW.ORG

RETIREE ENROLLMENT FORM

Name: _____ Employee #: _____

Date of Birth: ____/_____/_____ Gender: ☐Male ☐Female SSN #: _____-_____-_____

Address: _____

Apt/Building #: _____ State: _____ Zip Code: _____

Email: _____ Phone Number: _____-_____-_____

Medicare #: _____ Medicare B Effective Date: ____/____/____

MEDICAL PLANS

NON-MEDICARE PLANS - MEDICAL, VISION, PRESCRIPTION DRUGS

CareFirst BlueChoice Advantage PPO/Davis Vision	☐Single	☐Family
CareFirst BlueChoice HMO/Davis Vision	☐Single	☐Family
Kaiser Permanente HMO/NVA Vision	☐Single	☐Family

*MEDICARE PLANS WITH MEDICAL, VISION, PRESCRIPTION DRUGS

(MUST BE ENROLLED IN MEDICARE PARTS A AND B AND PROVIDE A COPY OF MEDICARE CARD)

CareFirst BlueChoice Advantage PPO/ Davis Vision	☐Single
	☐Family + 1 (One Person Enrolled In Medicare)
	☐Family + 2 (Two People Enrolled In Medicare)
CareFirst BlueChoice HMO/ Davis Vision	☐Single
	☐Family + 1 (One Person Enrolled In Medicare)
	☐Family + 2 (Two People Enrolled In Medicare)

*MEDICARE ADVANTAGE PLANS WITH PART D

(SEPARATE APPLICATION REQUIRED; MUST BE ENROLLED IN MEDICARE PARTS A AND B AND PROVIDE A COPY OF MEDICARE CARD)

Kaiser Medicare Advantage Plan/ NVA Vision	☐Single
	☐Family + 1 (One Person Enrolled In Medicare)
	☐Family + 2 (Two People Enrolled In Medicare)

(Additional plans on page 2)

CareFirst Medicare Advantage Plan (MAPD)/Davis Vision

☐ Single
☐ Two Party Coverage (Both 65+)

CareFirst Medicare Advantage Plan (MAPD)/Davis Vision with CareFirst BlueChoice HMO

☐ Family + 1 (One Person Enrolled In Medicare)
☐ Family + 2 (Two People Enrolled In Medicare)

CareFirst Medicare Advantage Plan (MAPD)/Davis Vision with CareFirst BlueChoice Advantage PPO

☐ Family + 1 (One Person Enrolled In Medicare)
☐ Family + 2 (Two People Enrolled In Medicare)

DENTAL PLANS

☐ CareFirst Dental PPO ☐ Single ☐ Family

☐ CareFirst Dental PPO with Orthodontics ☐ Single ☐ Family

☐ CIGNA Dental DHMO ☐ Single ☐ Family

ADD/REMOVE DEPENDENTS

Spouse's Name (Last, First, Middle):_____

Date of Birth: ____/_____/_____ SSN #: _____-_____-_____ Gender: ☐ Male ☐ Female

☐ Add ☐ Remove

Child's Name (Last, First, Middle): _____

Date of Birth: ____/_____/_____ SSN #: _____-_____-_____ Gender: ☐ Male ☐ Female

☐ Add ☐ Remove

Child's Name (Last, First, Middle): _____

Date of Birth: ____/_____/_____ SSN #: _____-_____-_____ Gender: ☐ Male ☐ Female

☐ Add ☐ Remove

Child's Name (Last, First, Middle): _____

Date of Birth: ____/_____/_____ SSN #: _____-_____-_____ Gender: ☐ Male ☐ Female

☐ Add ☐ Remove

Signature: _____ Date: ____/_____/_____