NEW HIRE ENROLLMENT FORM

Name: _____ Employee #: _____

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

Address: _____

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

Email: _____ Phone Number: _____-_____-_____

Spouse's Name (If Employed with WMATA):_____

Employee #: _____

(Please provide copies of original birth certificates and Social Security cards for yourself and your dependents (spouse and children), as well as your marriage certificate)

Medical Plans:

CareFirst PPO	☐Single	☐Family
BlueChoice HMO	☐Single	☐Family
Kaiser Permanente HMO	☐Single	☐Family

Dental Plans:

CareFirst Dental PPO	☐Single	☐Family
CareFirst with Orthodontics PPO	☐Single	☐Family
CIGNA Dental DHMO	☐Single	☐Family

☐I wish to opt out of coverage

(To do so, you must complete an opt-out form and provide proof of non-WMATA coverage to avoid automatic enrollment in the default plan).

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

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

Enroll into Plan: ☐Yes ☐No

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

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

Enroll into Plan: ☐Yes ☐No

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

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

Enroll into Plan: ☐Yes ☐No

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

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

Enroll into Plan: ☐Yes ☐No

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

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

Enroll into Plan: ☐Yes ☐No

Signature: _____ Date: _____/_____/_____