TEHW
Transit Employees' Health and Welfare Plan

Retiree Enrollment Form

ENROLLMENT DEADLINE: NOVEMBER 14, 2025

Complete this form only if you wish to:
- Make changes to your medical, dental, vision coverage
- Add/Remove dependents

Name: _____ Employee #: _____

Date of Birth: ____/_____/_____ Last four digits of SSN: _____

Email: _____ Phone Number: _____-_____-_____

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

NON–MEDICARE PLANS: MEDICAL, VISION, PRESCRIPTION DRUGS		
CareFirst PPO/Davis Vision	☐ Single	☐ Family
BlueChoice HMO/Davis Vision	☐ Single	☐ Family
Kaiser Permanente HMO/NVA Vision	☐ Single	☐ Family

***TRADITIONAL MEDICARE: MEDICAL, VISION, PRESCRIPTION DRUGS**	**Must be enrolled in Medicare Part A and B and provide a copy of your Medicare card.*
CareFirst BC Advantage PPO/Davis Vision	☐ Single ☐ Family + 1 (One Person Enrolled in Medicare) ☐ Family + 2 (Two People Enrolled in Medicare)
BlueChoice Medical 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 Part A and B and provide a copy of your Medicare card.*
Kaiser Medicare Advantage Plan with Part D/NVA Vision	☐ Single ☐ Family + 1 (One Person Enrolled in Medicare) ☐ Family + 2 (Two People Enrolled in Medicare)
BlueCross BlueShield Medicare Advantage PPO/Davis Vision	☐ Single ☐ Two Party Coverage (Both 65+)
BCBS MAPD/Davis Vision with BlueChoice HMO Medical	☐ Family + 1 (One Person Enrolled in Medicare) ☐ Family + 2 (Two People Enrolled in Medicare)
BCBS MAPD/Davis Vision with BlueChoice Advantage PPO Medical	☐ Family + 1 (One Person Enrolled in Medicare) ☐ Family + 2 (Two People Enrolled in Medicare)

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

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.

ADD/DROP DEPENDENTS

**Provide a copy of the Social Security card (dependents and spouse), original birth certificate (dependents), as well as a marriage certificate (spouse).*

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

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

☐ *Add ☐ Remove

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

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

☐ *Add ☐ Remove

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

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

☐ *Add ☐ Remove

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

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

☐ *Add ☐ Remove

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

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

☐ *Add ☐ Remove

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

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

☐ *Add ☐ Remove

SIGNATURE

Name: ______________________________ Date: ________________