


Universal Opt-Out/Drop Form

	Name _____ Employee No. _____
ELECTRONIC OPT-OUT FORM 	CHECK ONE: <input type="radio"/> Full-time Active Employee: Eligible for an annual payment of \$1,500 from the Premium Conversion Plan instead of medical/vision and dental coverage under the Plan. <input type="radio"/> Part-time Active Employee: Do not receive payment from the Premium Conversion Plan. <input type="radio"/> Retirees: Do not receive a payment from the Premium Conversion Plan and re-enroll in the Fund upon losing my other employer-sponsored coverage listed below or becoming Medicare-eligible

By signing this form, I understand that pursuant to the Washington Metropolitan Area Transit Authority Local 689 Premium Conversion Plan, I may elect to receive an annual payment for my employment status instead of medical/vision/dental coverage under the Plan. I further understand that by not electing medical/vision/dental coverage, I will not be obligated to contribute to the plan for that medical/vision/dental coverage. I may still be required to pay for other coverages under the Plan.

As noted above, I elect to receive the appropriate payment for my employment status and voluntarily waive my medical/vision/ dental coverage under the Plan. I understand that by waiving my rights to coverage, I am not entitled to medical/vision/ dental benefits available through the Plan. I further understand that if I wish to change this election for any reason, then it is a HIPAA-qualifying event.

Members with an outstanding premium balance may opt out of plan coverage but are not eligible for the \$1,500 premium conversion payment until the past-due balance is paid in full.

Members with Medicaid may opt out of plan coverage but are not eligible for the \$1,500.

☐ For **Part-time Employee:**

I now wish to terminate my coverage under the Transit Employees' Health & Welfare Plan effective.

☐ For **Retirees:**

I now wish to terminate my coverage under the Transit Employees' Health & Welfare Plan. I understand that I may only re-enroll in the Fund upon losing my other employer-sponsored coverage listed below or becoming Medicare eligible.

☐ For **Full-time Active Employees:**

For my election and waiver to be effective, I understand that I must have alternative non-METRO medical insurance. I certify that I have medical coverage through:

Name of Insurance Company: _____

Name of Primary Insured: _____

Policy Number and/or Group Number: _____

Telephone Number of Insurance Company: _____

*This election and waiver will not be valid until the Health & Welfare office has confirmed your alternative **non-METRO insurance coverage**.*

Print Employee's Name: _____ Employee Number _____

Signature: _____ Date: _____

Employee's SSN: _____ Employee's Telephone Number: _____

Employee Email: _____ Staff _____
Initials _____

Effective From _____ To _____

Health & Welfare staff must sign this form.