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

NEW HIRE ENROLLMENT CHECKLIST

To ensure your enrollment request is processed accurately and without delay, please submit all required documents to newhire@tehw.org

1. Member Enrollment
   - ☐ WMATA ID
   - ☐ Other Insurance Card (If Opting Out)

2. Spouse Enrollment
   - ☐ Social Security Card (*Eligible dependents must have a valid Social Security Number (SSN). To apply for a Social Security card, visit www.ssa.gov. To apply for an ITIN number, go to www.irs.gov)*
   - ☐ Marriage Certificate

3. Dependent Enrollment
   - ☐ Social Security Card (or ITIN Number)
   - ☐ Birth Certificate (Must include Member's or Enrolled Spouse's Name)
   - ☐ Custody/Adoption Documents (If applicable)

4. Birth Certificate
5. Social Security Card
6. Opt-Out *(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 premium conversion payment)*
   a. Copy of current insurance card
   b. Copy of Metro ID card

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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

☐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).

☐Spousal Credit

A separate form is required. The spousal credit form is available at the TEHW office or online at https://tehw.org/member-resources/forms-and-documents/

☐Update Beneficiary or Supplemental Life Insurance

(To enroll in Supplemental life or change your election, visit Metlife.com/mybenefits)

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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: _____/_____/_____

PAYROLL NUMBER

☐ **SINGLE** ☐ **FAMILY**

AUTHORIZATION TO DEDUCT
TRANSIT EMPLOYEES' HEALTH AND WELFARE PLAN CONTRIBUTIONS

To W.M.A.T.A., its successors and assigns, Washington, D.C.

I hereby authorize and direct you to deduct on or before the last day of each month from my wages, salary earnings or other compensation, including but not limited to sick leave pay or vacation pay, such as premium, contributions, and assessments as the Trustees of the Transit Employees' Health and Welfare Plan ("Trustees"} shall notify you are payable by me in accordance with provisions of the Agreement and Declaration of Trust providing the Trustees are empowered to receive the same, as long as no deductions are made from any workmen's compensation payments due me. The authorization shall be irrevocable for a period of one year from the date of execution hereof,, and shall be renewed automatically each year during the duration of any labor agreement between Local Division 689, A.T.U. and the W.M.A.T.A. unless I give the W.M.A.T.A. written notice of revocation, bearing my signature thereto, not less than thirty (30) days an not more than forty-five (45) days prior to any date upon which it becomes revocable. This authorization is made in accordance with the terms of the Agreement and Declaration of Trust between Local 689, Amalgamated Transit Union, AFL-CIO and W.M.A.T.A.

Date _____ Signature_____

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SPOUSAL CREDIT FORM

Employee's Name: _____ Employee #: _____
Spouse's Name: _____ Spouse's SSN #: ____-____-____

Is your spouse a WMATA employee? ☐Yes ☐No

If yes, please provide their employee #: _____

Insurance Company: _____
Group/Policy #: _____
Insurance Company Phone Number: _____-_____-_____

Under the 2012 collective bargaining agreement, employees are eligible to receive a spousal credit of up to $1,200 if their spouse waives coverage under the Transit Employees' Health & Welfare Plan. This credit may only be applied toward the employee's medical and dental benefit expenses as a Participant in the Plan. You must elect the spousal credit option each year.

A maximum of $100 per month will be applied to reduce the cost of your medical and dental insurance. This credit cannot be used to offset the cost of any supplemental life insurance or other voluntary benefits you may have elected.

For families consisting of the employee, spouse, and one or more children, the spousal credit will not fully offset the required contribution for family coverage.

By submitting this form, I acknowledge that my spouse is not covered by METRO medical insurance.

Please note: This election and waiver will not be effective until the Health & Welfare Office has verified your spouse's non-METRO insurance coverage through their employer-sponsored plan.

Participant's Signature: _____ Date: ___/____/____

Telephone Number: ____-____-_____

Staff Initials: _____ Effective Dates: ____/_____/_____ to ____/_____/_____

Universal Opt-Out/Drop Form

	Name	Employee No.
ELECTRONIC OPT-OUT FORM 	**CHECK ONE:** o **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. o **Part-time Active Employee:** Do not receive payment from the Premium Conversion Plan. o **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.

o For **Part-time Employee:**

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

o For **Retirees:**

Inow wish toterminate 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.

o 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.