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

SPOOT FORM

Our records indicate that you and your child are eligible for coverage under the Transit Employees' Health & Welfare Plan. According to Appendix B, Section H (5) of the agreement between the Washington Metropolitan Area Transit Authority (WMATA) and Local 689 of the Amalgamated Transit Union AFL-CIO, effective May 1, 1995:

"If two or more employees of the same family are eligible for separate family coverage, their coverage shall be consolidated into one family plan."

In accordance with this provision, you are required to decide whether you or your spouse will carry the family plan coverage. Please indicate your selection by completing the enclosed form, which confirms who will maintain the family coverage and who will be listed as a dependent effective _____/_____/_____ .

This form also allows you to add or maintain your dependent child's coverage under your plan. This arrangement may be voided at any time by either you or your child. Please note that your child is only eligible to remain on your plan until the end of the month in which they turn 26, unless otherwise specified by the plan.

Primary Member

Name (Print): _____ Employee #: _____

Signature: _____

Spouse

Name (Print): _____ Employee #: _____

Signature: _____

Dependent (Child)

Name (Print): _____ Employee #: _____

Signature: _____

(Continued on Page 2)

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

Please return the completed form to the Health and Welfare office using the enclosed self-addressed envelope.

If we do not receive your response by ____/_____/_____, the family plan coverage will automatically be assigned to the employee whose birth date occurs first (month and day) and/or the dependent will be placed on the default plan.

I, _____, agree that _____ will be added to my coverage as a dependent, effective _____/_____/_____

Signature: _____ Date: ____/_____/_____