TRANSIT EMPLOYEES' HEALTH & WELFARE Plan Dependent Change Form

Full-Time Regular ☐ Retiree ☐ Part-Time ☐ New Service ☐

Employee Name ______________________ **Employee #** ____________

Address ____

Zip ____________ **Daytime Phone** ______________________ **SS#** _____/_____/_____

You must provide copies of the original birth certificate, Marriage Certificate, and SSN Card for all dependents on this form.

I AM CURRENTLY ENROLLED/ OR ENROLLING IN THE BENEFIT PROGRAM LISTED BELOW

(CHECK ONE)

- **Kaiser Permanente** ☐ Single ☐ Family
- **BlueChoice HMO** ☐ Single ☐ Family
- **CareFirst BC Advantage (PPO)** ☐ Single ☐ Family
- **CareFirst BC Medicare Advantage (PPO)** ☐ Single ☐ Family

(CHECK ONE)

- **CIGNA dental** ☐ Single ☐ Family
- **CareFirst dental** ☐ Single ☐ Family
- **CareFirst dental with Ortho** ☐ Single ☐ Family
- **Delta Dental** ☐ Single ☐ Family

If you elect BLUECHOICE HMO as your provider, you must contact them and choose a primary care physician.
If you remove a dependent, provide their address on the reverse side so that we may send them a COBRA notice.

SPOUSE ☐ Add ☐ Remove	Employed by WMATA ☐ Yes ☐ No		
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
CHILD ☐ Add	☐ Remove		
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
CHILD ☐ Add	☐ Remove		
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
CHILD ☐ Add	☐ Remove		
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
CHILD ☐ Add	☐ Remove		
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
CHILD ☐ Add	☐ Remove		
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F
CHILD ☐ Add	☐ Remove		
Name (Last, First, Mi)	Social Security	Date of Birth	Sex
			☐ M ☐ F

Signature: ______________________________ **Date:** ______________

Removed Dependent Contact Information

Name: _____ Phone: (_____)-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

TEHW
Transit Employees' Health and Welfare Plan