

# Transit Employees'



## HEALTH AND WELFARE PLAN



2701 WHITNEY PLACE • SUITE 100 • FORESTVILLE, MARYLAND 20747-3457  
 PHONE: (301) 568-2294 • FAX: (301) 568-7302  
 WEBSITE: <http://teh.w.org> • EMAIL: [info@teh.w.org](mailto:info@teh.w.org)

### TRANSIT EMPLOYEES LOCAL 689 HEALTH BENEFIT ENROLLMENT

**Employee Name:** \_\_\_\_\_ **Employee #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Gender:**  Male  Female

**Address:** \_\_\_\_\_

**Cell or Home:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Spouse's Name if working for WMATA:** \_\_\_\_\_ **Employee #:** \_\_\_\_\_

#### MEDICAL/DENTAL ENROLLMENT *(Please check one)*

***Provide copies of original birth certificates and SSN cards for yourself, and dependents below (spouse & children), and marriage certificate.***

**Medical Plans**

- |                               |                          |        |                          |        |
|-------------------------------|--------------------------|--------|--------------------------|--------|
| CareFirst PPO Medical         | <input type="checkbox"/> | Single | <input type="checkbox"/> | Family |
| Blue Choice HMO Medical       | <input type="checkbox"/> | Single | <input type="checkbox"/> | Family |
| Kaiser Permanente HMO Medical | <input type="checkbox"/> | Single | <input type="checkbox"/> | Family |

**Dental Plans**

- |                          |                          |        |                          |        |
|--------------------------|--------------------------|--------|--------------------------|--------|
| CareFirst PPO Dental     | <input type="checkbox"/> | Single | <input type="checkbox"/> | Family |
| CareFirst PPO with Ortho | <input type="checkbox"/> | Single | <input type="checkbox"/> | Family |
| CIGNA DMO Dental         | <input type="checkbox"/> | Single | <input type="checkbox"/> | Family |

I wish to Opt-Out of coverage. *(You must complete an Opt-Out form and provide proof of non-WMATA coverage to avoid being enrolled in the default coverage)*

	Name (Last, First, MI)	Social Security #	Date of Birth	Gender
<b>Spouse</b> <input type="checkbox"/> Enroll				<input type="checkbox"/> M <input type="checkbox"/> F
<b>Child</b> <input type="checkbox"/> Enroll				<input type="checkbox"/> M <input type="checkbox"/> F
<b>Child</b> <input type="checkbox"/> Enroll				<input type="checkbox"/> M <input type="checkbox"/> F
<b>Child</b> <input type="checkbox"/> Enroll				<input type="checkbox"/> M <input type="checkbox"/> F
<b>Child</b> <input type="checkbox"/> Enroll				<input type="checkbox"/> M <input type="checkbox"/> F

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

