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://tehw.org • EMAIL: info@tehw.org

DELTA DENTAL ENROLLMENT

Date of Notice: _____

Name: _____

Address: _____

_____

Phone No: _____ Date of Retirement: _____

Payroll # _____ SSN#: _____

As a retiree, **you** will be **automatically enrolled** in the Delta Dental Plan. However, **your spouse and family members will not be covered in Delta** until you request enrollment in the family plan by completing this form and returning it to the Health and Welfare Office within the **first 30 days** of this notification.

NO RESPONSE IS NEEDED IF YOU DO NOT WISH TO ENROLL YOUR DEPENDENTS.

_____**I wish to enroll my dependents in the Delta Dental program at an additional cost of $13.00 per month.**

_____**I wish to Opt-Out of the Delta Dental program**

. All premium payments will be deducted from your pension check each month.

Signature _____ **Date**_____