# Universal Opt-Out/Drop Form

| YOUR NAME AND EMPLOYEE NUMBER | Name Employee No. |
|---|---|
| CHECK ONE: | ❑ **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.<br>❑ **Part-time Active Employee:** Do not receive a payment from the Premium Conversion Plan.<br>❑ **Retirees:** Do not receive a payment from the Premium Conversion Plan and are not eligible to rejoin the Plan at any time. |

*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 as noted above for my employment status instead of such medical/vision/dental coverage under the Plan. I further understand that by not electing the medical/vision/dental coverage, I will also not be obligated to make any contributions for that medical/vision/dental coverage to the Plan. I may still be required to pay for other coverages under the Plan.*

*I elect to receive the appropriate payment for my employment status as noted above and voluntarily waive my medical/vision/dental coverage under the Plan. I understand that by waiving my rights to the coverage, I am not entitled to medical/vision/dental benefits available through the Plan. I further understand that regardless of the reason that I wish to change this election, I will not be able to receive medical/vision/dental coverage under the Plan until January 1st immediately following the next Open Enrollment period.*

❑ For **Part-time Employee:**
*I now wish to terminate my coverage under the Transit Employees' Health & Welfare Plan effective ______________. I understand that I will not be able to join the Plan again until January 1st of the following year.*

❑ For **Retirees:**
*I now wish to terminate my coverage under the Transit Employees' Health & Welfare Plan. I understand that I will not be able to rejoin the Plan at any time in the future.*

❑ 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:* ____________________

*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 ____________________

**This form must be signed by Health & Welfare staff.**