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. ○ **Part-time Active Employee:** Do not receive payment from the Premium Conversion Plan. ○ **Retirees:** Do not receive a payment from the Premium Conversion Plan and re-enroll in the Fund upon losing my other employer-sponsored coverage listed below or becoming Medicare-eligible

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 for my employment status instead of medical/vision/dental coverage under the Plan. I further understand that by not electing medical/vision/dental coverage, I will not be obligated to contribute to the plan for that medical/vision/dental coverage. I may still be required to pay for other coverages under the Plan.

As noted above, I elect to receive the appropriate payment for my employment status and voluntarily waive my medical/vision/ dental coverage under the Plan. I understand that by waiving my rights to coverage, I am not entitled to medical/vision/ dental benefits available through the Plan. I further understand that if I wish to change this election for any reason, then it is a HIPAA-qualifying event.

Members with an outstanding premium balance may opt out of plan coverage but are not eligible for the $1,500 premium conversion payment until the past-due balance is paid in full.

Members with Medicaid may opt out of plan coverage but are not eligible for the $1,500.

- For **Part-time Employee:**
  I now wish to terminate my coverage under the Transit Employees' Health & Welfare Plan effective.
- For **Retirees:**
  I now wish to terminate my coverage under the Transit Employees' Health & Welfare Plan. I understand that I may only re-enroll in the Fund upon losing my other employer-sponsored coverage listed below or becoming Medicare eligible.
- 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: _____

Name of Primary Insured: _____

Policy Number and/or Group Number: _____

Telephone Number of Insurance Company: _____

This election and waiver will not be valid until the Health & Welfare office hasconfirmed 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** _____

Health & Welfare staff must sign this form.