**Transport Workers Union-MTA Health & Welfare Trust**
2150 W. 18th Street, Suite 112, Houston, TX 77008
(713) 868-1995 (office) (713) 868-1908 (fax)
**website: www.twu-hwt.org** **email: tallen@twu-hwt.org**

# ___Enrollment ___Change

**Please press hard and print clearly.**

## CHECK DESIRED PLAN

| | | |
|---|---|---|
| ___ Kelsey Care<br>___ Cigna/HMO<br>___ Cigna/PPO<br>___ Aetna/PFFS<br>___ PFFS/KC<br>___ PFFS/HMO<br>___ PFFS/PPO | ___ Dental PPO<br>___ Dental HMO<br>Dentist #_____ | ____Employee/Only<br>____Employee/Child<br>____Employee/Spouse<br>____Employee/Family |

__Name Change
__Address Change
__Other

**ADD/CANCEL** **DATE:** _____
__Marriage: __Adoption __Birth
__Divorce: __Termination __Death

__Active
__Retiree
__S. Spouse

| Status | Premium | Code | Amount |
|---|---|---|---|
| | Medical | | |
| | Dental | | |
| | CSI | | |

Employee Last Name | First Name | MI | Payroll #

Current Address | Apt. # | City | State | Zip

Social Security # | Date of Birth | Contact # | Facility

***Remarks:***

| A/C | Last Name | First Name | MI | Date of Birth | Relationship | Social Security # |
|---|---|---|---|---|---|---|
| | | | | | **SPOUSE** | |
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***I hereby authorize payroll deductions for insurance under the terms of Transport Worker's Union-MTA Health & Welfare Trust plan. I am aware that a change in dependent coverage may affect my deduction rate. I am aware that this agreement is for a full year from the effective date of the coverage.***

**MEDICAL EFFECTIVE DATE:** _____ **DENTAL EFFECTIVE DATE:** _____

Employee Signature: _____ Date: _____ HWT Representative: _____ Date: _____

**White: HWT** **Canary: Metro** **Pink: Employee**