Washington Teachers' Union
Amplifying the voice of DC teachers
1239 Pennsylvania Avenue SE * Washington, DC 20003 * 202.517.1477 * www.local6.org

WTU RETIREES CHAPTER
2026 MEMBERSHIP AND BENEFITS APPLICATION

PERSONAL INFORMATION

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: Male ____ Female ____ Cell Phone: _____

SSN: _____ Personal Email: _____

Birth Date: _____ Retirement Date: _____

PAYMENT

Retiree Chapter Dues: $60.00 per year.

Please make checks payable to WTU noting 2026 Retiree Chapter in the memo. Your enrollment will not be processed until payment is received. Please include enrollment application along with payment.

Mail To: Washington Teachers' Union
ATTN: WTU Retirees Chapter
1239 Pennsylvania Ave, SE
Washington, DC 20003

_____ _____
Signature *Date*

If you have any questions, please call 202-517-1477 or email benefits@wtulocal6.net.

E. CHECK LIST and RATE CHART

CHECK LIST

- ☐ Determine whether you need Vision Benefits, Dental Benefits or both
- ☐ Decide if you need "Single" or "Family" coverage
- ☐ If you decide on "Family" be sure to have each dependent's birth date and SSN
- ☐ Complete online enrollment and add your dependents **ONLINE**

RATES:

All retirees must sign up to be a member of the WTU Retiree Chapter every year. Membership does not carry over from one year to the next. Retirees MUST pay yearly retiree dues to be eligible for Dental and/or Vision benefits.

Membership Dues are: $ 60.00 / year.

WTU RETIREES CHAPTER – 2026 DENTAL / VISION BENEFITS RATES (Based on 12 months)				
Chapter Dues	Vision (Single or Family) Yearly Cost	Dental Single	Dental Family	Total Due
$60.00				$60.00
$60.00	$400.80			$460.80
$60.00	$400.80	$620.04		$1,080.84
$60.00	$400.80		$1,240.08	$1,700.88
$60.00		$620.04		$680.04
$60.00			$1,240.08	$1,300.08
PLEASE CIRCLE DENTAL PLAN TYPE: In-Network or PPO				

Questions? Call WTU 202-517-1477

You are required to re-enroll in Membership, Vision, and Dental benefits during open enrollment every year. Open enrollment occurs each year – November 1 - November 30.

THIS IS NOT A HEALTH INSURANCE PLAN

THIS PLAN COVERS ONLY DENTAL AND/OR VISION BENEFITS, DEPENDING ON YOUR ELECTION

F. 2026 OPTIONS RATE CHART

OPTIONS CHART:
Use the Options Chart below to help you determine the cost of your benefits for 2026. The chart includes all possible choices.

Option 1	COST
Dental (Member Only) & Vision (Member Only) + Membership Dues	$1,080.84
Option 2	
Dental (Family) & Vision (Family) + Membership Dues	$1,700.88
Option 3	
Dental (Member Only) + Membership Dues	$680.04
Option 4	
Dental (Family) + Membership Dues	$1,300.08
Option 5	
Vision (Member Only) + Membership Dues	$460.80
Option 6	
Vision (Family) + Membership Dues	$460.80
Option 7	
Retiree's Chapter Membership Dues Only	$60.00

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FULFILLING THE COMMITMENT TO BUILD GREAT MINDS

2026 FAMILY/DEPENDENT INFORMATION

If you have a dependent on your benefits currently, please put their name and information below.

****Dependent Verification Documentation Only needed if adding a dependent for the first time.****

Please attach a copy of one of the following forms of documentation for a dependent if you are adding them to your dental and/or vision 1coverage for the first time.

Child:	Birth Certificate
Adopted Child:	Adoption certificate or court documentation
Spouse:	Marriage Certificate
Domestic Partner:	Domestic partner affidavit or notarized document

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FULFILLING THE COMMITMENT TO BUILD GREAT MINDS

Dependent 1

Full Name: _____ _____ _____
Last *First* *MI*

SSN: ___ - ___ - ___

Relationship: Spouse ☐ Child ☐ Domestic Partner ☐ Child of Domestic Partner ☐

Date of Birth: _____ Male ☐ Female ☐

Disabled? YES ☐ NO ☐

Full Time Student? YES ☐ NO ☐

Dependent 2

Full Name: _____ _____ _____
Last *First* *MI*

SSN: ___ - ___ - ___

Relationship: Spouse ☐ Child ☐ Domestic Partner ☐ Child of Domestic Partner ☐

Date of Birth: _____ Male ☐ Female ☐

Disabled? YES ☐ NO ☐

Full Time Student? YES ☐ NO ☐

Dependent 3

Full Name: _____ _____ _____
Last *First* *MI*

SSN: ___ - ___ - ___

Relationship: Spouse ☐ Child ☐ Domestic Partner ☐ Child of Domestic Partner ☐

Date of Birth: _____ Male ☐ Female ☐

Disabled? YES ☐ NO ☐

Full Time Student? YES ☐ NO ☐