DISTRICT OF COLUMBIA OPEB BENEFITS ENROLLMENT FORM

REGISTRATION FORM

OPEN ENROLLMENT 2014 ENROLLMENT FORMS MUST BE POSTMARKED AND RETURNED BY December 12, 2014

☐ New Enrollment ☐ Change ☐ Cancellation

1 Employee Information: (All information is required)

Last Name:	First Name :	Middle Initial:
Home Address:		
City:	State: ZIP:	EMPL ID:
SSN:	Date of Birth (MM/DD/YYYY):	Gender:
Home Phone:	Work Phone:	Email Address:
Agency:	Position Title:	

2 Health Insurance: DCEHB provides coverage for benefits eligible retirees. Please elect your tier coverage and carrier below. . .

An employee or family member cannot be covered under more than one DCEHB enrollment.

Coverage Tier:	☐Employee Only	☐Employee plus One	☐ Employee and Family	☐ I Waive Health Coverage
☐ AETNA - CDHP ☐ AETNA- HMO ☐ AETNA - PPO	☐ Kaiser Permanente- HMO		☐ United Healthcare- Choice Plan Nationwide	☐ Domestic Partner (Partner only) ☐ Domestic Partner (Partner & family) (Must meet requirement s of 29 DCMR 8001.1)

3 Dependents: List all individuals to be covered by this enrollment. Coverage is available to dependents up to age 19 (up to age 25 for full time students)

1=Spouse 2=Son 3=Daughter 4=Domestic Partner (Domestic Partners must meet the requirements of 29 DCMR 8001.1)

Coverage	Name	Relationship*	Gender	Date of Birth	SSN	Full Time College Student?
☐Medical ☐Dental ☐Vision						☐Yes ☐No
☐Medical ☐Dental ☐Vision						☐Yes ☐No
☐Medical ☐Dental ☐Vision						☐Yes ☐No
☐Medical ☐Dental ☐Vision						☐Yes ☐No
☐Medical ☐Dental ☐Vision						☐Yes ☐No
☐Medical ☐Dental ☐Vision						☐Yes ☐No

In making this election I understand that:

I cannot change or revoke this enrollment at anytime during the year for which this election is made, unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth of a child, adoption of a child). Additionally, I understand that I have 31 days from my date of separation to make my first insurance payment to the carrier. Failure to make timely premium payments will result in my benefits being cancelled.

"Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

Signature: ➡	**Date:**
AGENCY:	***Date Processed:***
Signature of Authorized Agency Official:	***Effective Date:***