



GOVERNMENT OF THE DISTRICT OF COLUMBIA  
**OPEB BENEFITS ENROLLMENT FORM**



New Enrollment

Change

Cancellation

1. Employee Information: (All information is required)				
Last Name:		First Name:		MI:
Address:				
City:			State:	Zip:
EMPL ID:	DOB (MM/DD/YYYY):		Gender:	
Phone:	Email:		Agency:	

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:	Self Only	Self + 1	Family	I waive health coverage.	Domestic Partner (Partner Only)*	Domestic Partner (Partner & Family)*
Aetna CDHP	Aetna HMO	Aetna PPO	Kaiser Permanente	UnitedHealthcare Choice		

\*Must meet requirements of 29 DCMR 8001.1

3. Dependents: List all individuals to be covered by this enrollment. Coverage is available to dependents up to age 26. *1 = Spouse; 2 = Son; 3 = Daughter; 4 = Domestic Partner* (*must meet requirements of 29 DCMR 8001.1)				
Name (First, MI, Last)	Relation*	Gender	DOB	SSN

**In making this election, I understand that:**

- I cannot change or revoke this enrollment at any time 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, employment or termination of employment of spouse, 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.

**Please Note:** Once you are no longer working, your **timeframe for Medicare enrollment is three months before you reach age 65 (the month you turn 65) and ends three months after that birthday month**. If you are over age 65, please verify with your selected carrier for more information regarding the coordination of benefits.

**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 were provided by the applicant.

Retiree Signature:	Date:
Authorized Agency Official Signature:	Date:

**DCHR OFFICE USE ONLY**

Date Processed:	Effective Date:
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