



GOVERNMENT OF THE DISTRICT OF COLUMBIA
COBRA COVERAGE CHANGE ELECTION FORM
(Form for Switching COBRA Continuation Coverage)



Instructions: To change the benefit option(s) for your COBRA continuation coverage to something different than what you or the participating employee had on the last day of coverage, complete this form and return it to us. Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options. This Election Form must be completed and returned by mail or by email. If mailed, it must be post-marked no later than 60 days after the date of this notice. Send completed Election Form to:

D.C. Department of Human Resources
 Benefits and Retirement Administration
 1015 Half Street, S.E. 9th Floor, Washington, D.C. 20003
dchr.benefits@dc.gov

PLEASE NOTE: *THIS IS NOT YOUR ELECTION NOTICE* YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE TO SECURE YOUR COBRA CONTINUATION COVERAGE.

2021 TCC/COBRA Monthly Rates (includes full premium plus 2% administrative charge)							
	Aetna CDHP	Aetna HMO	Aetna PPO	Carefirst HMO	Carefirst PPO	Kaiser Permanente	UnitedHealthcare Choice
Self	\$311.26	\$849.03	\$814.82	\$765.56	\$864.54	\$682.25	\$813.46
Self + 1	\$611.82	\$1668.92	\$1601.71	\$1508.16	\$1651.27	\$1303.23	\$1553.69
Family	\$899.45	\$2453.48	\$2354.66	\$2212.48	\$2533.09	\$1999.06	\$2383.40

PERSONAL INFORMATION				
Last Name		First Name		MI
Mailing Address (Street, #)		City	State	Zip
Phone (XXX-XXX-XXXX)	Email		Agency	
EMPL ID	DOB (MM/DD/YYYY)		SSN (XXX-XX-XXXX)	
			Gender	

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

I (We) would like to change the COBRA continuation coverage option(s) as indicated below:

Previous Coverage:

Coverage Tier			Carrier			
Self	Domestic Partner* (partner only)	Aetna CDHP	Carefirst HMO	Kaiser Permanente	UnitedHealthcare Choice Open Access	
Self + 1	Domestic Partner* (partner + family)	Aetna HMO	Carefirst PPO	Kaiser Permanente HMO		
Family	I waive health coverage.	Aetna PPO				
*Must meet 29 DCMR 8001.1						

Dependents: List all individuals to be covered. Medical coverage is available to dependents up to age 26.

Relation Code: 1= Spouse 2= Son 3 = Daughter 4 = Domestic Partner

Name (first, last)	Rel.	Gender	DOB	SSN

SIGNATURE

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).

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 was provided by the applicant.

Signature:	Date:
Print Name:	Relationship to individual(s) listed above:

CONTACT

DCHR Benefits & Retirement Administration
202.442.7627
dchr.benefits@dc.gov
dchr.dc.gov