GOVERNMENT OF THE DISTRICT OF COLUMBIA

COBRA CONTINUATION COVERAGE ELECTION FORM (for individuals not currently on COBRA)

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan. However, if you fail to elect COBRA continuation coverage and the premium assistance within 60 days of receipt of this form, you may be ineligible for the premium assistance and the additional COBRA election period under the ARP. 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

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. If you don't submit a completed Election Form by the due date shown above, you may lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed Election Form before the due date.

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) elect the following COBRA continuation coverage as indicated below:												
Coverage Tier				**Carrier**								
☐	Self	☐	Domestic Partner* (*partner only*)	☐	Aetna CDHP	☐	Carefirst HMO	☐	Kaiser Permanente HMO	☐	UnitedHealthcare Choice Open Access	
☐	Self + 1	☐	Domestic Partner* (*partner + family*)	☐	Aetna HMO	☐	Carefirst PPO					
☐	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