GOVERNMENT OF THE DISTRICT OF COLUMBIA #141326

TEMPORARY CONTINUATION OF COVERAGE BENEFITS ENROLLMENT FORM

You have the right to temporarily continue your health care coverage in your current DCEHB group health plan for up to 18 months after your separation instead of converting to a non-group contract. **You must pay the full premium** (both the employee and government shares) **plus a 2 percent administrative charge**. If you choose to continue your coverage in your current DCEHBP plan, your 31-day temporary extension of coverage is at no cost. Your enrollment charges begin on the day after the 31-day period of free coverage ends. You have 60 days from the date of your separation to elect TCC (Temporary Continuation of Coverage).

TCC/COBRA Rates (*includes full premium plus 2% administrative charge*)					
	Aetna CDHP	**Aetna HMO**	**Aetna PPO**	**Kaiser Permanente**	**UnitedHealthcare Choice**
Self	$393.04	$838.73	$849.71	$649.04	$785.95
Self + 1	$772.59	$1,648.67	$1,670.28	$1,239.79	$1,501.15
Family	$1,135.80	$2,423.70	$2,455.48	$1,901.74	$2,302.80

1. Employee Information			
Last Name:	**First Name:**		**MI:**
Address:			
City:	**State:**	**Zip:**	
EMPL ID:	**SSN:**	**DOB:**	**Gender:**
Phone:	**Email:**	**Agency:**	

2. Health Insurance: Please elect your coverage tier and carrier below.

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*)	**Relationship***	**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.*

Employee Signature:	**Date:**
Authorized Agency Official Signature:	

DCHR OFFICE USE ONLY

Date Processed:	**Division Code** (DCHR use only for Aetna)
Active Coverage End Date:	*Active* ☐ *Housing* ☐ *Disability* ☐ *Extension* ☐ *UDCRET* ☐
TCC/COBRA Start Date:	*Retiree* ☐ *DCOPR* ☐ *ActiveAnc* ☐ *ANC3C* ☐
Date of First Payment to Carrier:	PayFlex Systems USA, Inc. Benefits Billing Department P.O. Box 953374, St. Louis, MO 63195-3374 Phone: 888-678-7835

***Please Note**: This form and listed rates are effective for calendar year 2019. Please email dchr.benefits@dc.gov for questions.*