District of Columbia Retirement Board (DCRB)
Benefits Department
900 7th Street, NW, 2nd Floor •Washington, DC 20001
Telephone: (202) 343-3272 • Toll Free: (866) 456-3272 • Fax: (202) 566-5001
www.dcrb.dc.gov

Health Benefits Registration Form

If you were hired on or after October 1, 1987, you participate in the District healthcare program. Complete this form to enroll in the District Plan upon retirement or to make changes in your coverage during Open Enrollment periods or upon a change in family status. If you have questions, please contact the DCRB Member Services Center at the numbers listed above. Please return the completed form to DCRB.

Part A: Personal Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth (MM/DD/YYYY): _____/_____/_____ Social Security #: _____ -_____ -_____

Work Phone: _____- _____ -_____ Home Phone: _____- _____ -_____

Mailing Address: _____
Street

_____ _____ _____
City State Zip Code

Are you married? Yes ☐ No ☐ Sex: Male ☐ Female ☐

If you are covered by Medicare, select all that apply: Part A ☐ Part B ☐ Part D ☐

Medicare Claim #:_____ *(Please attach a copy of your Medicare card when returning this form.)*

Part B: Plan You are Currently Enrolled In

Present Plan Name: _____ Enrollment Code: _____
(If applicable)

Part C: Plan You are Enrolling In or Changing To

Name of Plan: _____ Enrollment Code: _____

Type of Enrollment: Self Only ☐ Self Plus One (1) ☐ Self and Family ☐

Part D: Cancellation/Waiver Option *(Skip this section if it does not apply to you.)*

I elect: *(Please check one of the following boxes.)*

☐ To **cancel** my present enrollment. I understand that if I choose to cancel my enrollment, I **may not re-enroll**.

☐ To **waive** my enrollment. I understand that if I choose this option, I must be enrolled in Medicare. (Please attach a copy of your Medicare card.)

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Part E: Eligible Dependents

In the spaces below, list all eligible family members without exception. List spouse first, then your unmarried dependent children. Do not list parents or others who are not eligible family members. They will not receive benefits even if listed. If you require more space, please attach an additional sheet of paper.

Name & Relationship of Family Member	Social Security Number	DOB (MM/DD/YYYY)	Sex (Choose one)
	_____-_____-_____	____/____/_____	Male ☐ Female ☐
	_____-_____-_____	____/____/_____	Male ☐ Female ☐
	_____-_____-_____	____/____/_____	Male ☐ Female ☐
	_____-_____-_____	____/____/_____	Male ☐ Female ☐
	_____-_____-_____	____/____/_____	Male ☐ Female ☐
	_____-_____-_____	____/____/_____	Male ☐ Female ☐

Part F: Authorization

I elect to enroll/change my health benefits plan as shown on the first page of this form. If enrolling or changing, I authorize deductions from my annuity to cover my share of the cost of the enrollment.

_____ _____/_____/_____

Your signature (Do not print) Date (MM/DD/YYYY)

This form is not valid without a signature!
Please complete and return this form to DCRB.

Part G: For DCRB Use Only

This section is to be completed by DCRB. **Please do not mark this section.**

Name of Office: District of Columbia Retirement Board
900 7th Street, NW, 2nd Floor
Washington, DC 20001

Date Received By DCRB: _____/_____/_____
Effective Date of Election: _____/_____/_____

Effective Date of Termination Of Enrollment: _____/_____/_____
Health Plan Report Number: _____

Payroll Office #: _____
Insurance Group #: _____
Compensation Unit Code: _____
(Subgroup #)

_____
Signature of DCRB Representative

Remarks: