HEALTH BENEFITS ENROLLMENT REGISTRATION FORM FOR RETIRED MEMBERS OF THE DISTRICT OF COLUMBIA POLICE OFFICER AND FIREFIGHTERS' AND TEACHERS' RETIREMENT PLANS

If you were hired on or after October 1, 1987, you may participate in the District of Columbia Employees Health (DCEHB) program. If you are eligible, complete this form to elect to continue you DCEHB coverage upon retirement or to make changes in your current coverage during Open Enrollment periods or upon a change in family status. *If you are making changes at a time other than the Open Enrollment period, you must provide proof of a qualifying life event.*

☐ **Open Enrollment** ☐ **Change** ☐ **Cancellation** **Effective Date:** _____

1 Member Information: (All information is required)

Last Name:	**First Name:**	**Middle Initial:**
Home Address:		
City:	**State:**	**ZIP Code:**
SSN:	**Date of Birth:**	**Gender:**
Home Phone:	**Cell Phone:**	**Email:**
Are you are covered by Medicare? ☐ Yes ☐ No **If "Yes," please select all that apply:** ☐ **Part A** ☐ **Part B** **Part C** ☐		**Medicare Claim #:**
Are you currently enrolled under another DCEHB plan, such as under your spouse/domestic partner's plan? ☐ Yes ☐ No		

2 Health Insurance: DCEHB provides coverage for benefits eligible retirees. Please elect your tier coverage and carrier below. A retiree or family member cannot be covered under more than one DCEHB enrollment.

Please select one coverage tier and one health plan.

Coverage Tier:	☐Self Only (1)	☐ Self plus One (2)	☐ Self and Family (3)	☐ I Waive Health Coverage
Health Plan:	☐ AETNA - CDHP (DCAC) ☐ AETNA- HMO (DCHM) ☐ AETNA – PPO (DCAP)	☐ Kaiser Permanente- HMO (DCKP) ☐ United Healthcare- Choice Plan Nationwide (DCMD)	☐ CareFirst HMO (DCFH) ☐ CareFirst PPO (DCFP)	

3 Dependents: Coverage is available to child dependents up to age 26, ***Relationship Code:*** 1=Spouse 2=Son 3=Daughter 4=Domestic Partner (must meet the requirements of 29 DCMR 8000 et seq.) 5 = Disabled Child.

List all dependents to be covered by this enrollment.

Name	Relationship*	Gender	Date of Birth*	SSN	Full Time College Student?
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No

*If the dependent is beyond age 26 and a disabled child, DCRB requires that you also submit a medical certification statement. Please contact DCRB for necessary documentation requirements.

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, domestic partnership termination, death of a spouse/domestic partner or child, birth or adoption of a child).

☐ If enrolling or changing, I understand that my share of the premiums will be deducted from my annuity.

☐ If I am electing to cancel my present enrollment I understand that I may not re-enroll in the future.

"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."

4	**Member Signature:** ➡	**Date:**

Please return the completed form to DCRB at the address, email, or fax below.

District of Columbia Retirement Board (DCRB)
Benefits Department
900 7th Street, NW, 2nd Floor
Washington, DC 20001

Email: dcrb.benefits@dc.gov **Fax:** (202) 566-5001

If you have questions, please contact the DCRB Member Services Center at (202) 343-3272 or toll free at (866) 456-3272.

FOR DCRB USE ONLY	
	Date Processed: _____
Signature of Authorized DCRB Official	***Coverage Effective:*** _____
Title	***Premium Deduction Date:*** _____