GOVERNMENT OF THE DISTRICT OF COLUMBIA

TEMPORARY CONTINUATION OF COVERAGE (TCC) BENEFITS ENROLLMENT FORM

- You have the right to temporarily continue your current DCEHB group health plan coverage for **up to 18 months after your separation**. **You must pay the full premium**, both the employee and government portions, plus a 2% administrative charge.
- If you choose to continue your current DCEHB health plan coverage, your **31-day temporary extension of coverage is at no cost. Enrollment charges begin on the day after the 31-day period of free coverage ends**.
- **You have 60 days from your separation date to elect TCC**.

2022 TCC/COBRA Rates (*includes full premium plus 2% administrative charge*)							
	Aetna CDHP	**Aetna HMO**	**Aetna PPO**	**CareFirst HMO**	**CareFirst PPO**	**Kaiser Permanente**	**UnitedHealthcare Choice**
Self	$342.39	$891.48	$868.17	$765.56	$864.54	$732.25	$837.87
Self + 1	$673.00	$1752.37	$1706.60	$1508.16	$1651.27	$1398.59	$1600.32
Family	$989.39	$2576.15	$2508.86	$2212.48	$2533.09	$2145.42	$2454.92

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.

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 19 (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). **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 was provided by the applicant.	
Signature:	Date:
Signature of Authorized Agency Official:	Date:

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

DCHR OFFICE USE ONLY

Date Processed:	
Active Coverage End Date:	
TCC/COBRA Start Date:	
Date of First Payment to Carrier:	

Division Code (DCHR use only for Aetna)				
☐ *Active*	☐ *Housing*	☐ *Disability*	☐ *Extension*	☐ *UDCRET*
☐ *Retiree*	☐ *DCOPR*	☐ *ActiveAnc*	☐ *ANC3C*	

PayFlex Systems USA, Inc.
Benefits Billing Department
P.O. Box 953374, St. Louis, MO 63195-3374
Phone: 888-678-7835