



DISTRICT OF COLUMBIA EMPLOYEES BENEFITS ENROLLMENT REGISTRATION FORM

☐ 2016 New Enrollment ☐ Change

1 Employee Information: (All information is required)					
Last Name:		First Name:		Middle Initial:	
Home Address:					
City:		State:	Zip:	Employee ID Number:	
Social Security Number:		Gender:		Date of Birth (MM/DD/YYYY):	
Home Phone:		Work Phone:		Email Address:	
Agency:		Position Title:		Work Location:	

2 Health Insurance: DCEHB provides coverage for full-time and part time benefits eligible employees. Your payroll deductions will be deducted on a pre-tax basis. If enrolling a Domestic Partner or Domestic Partner and family, your benefits will be deducted after-tax. Employees pay a share of the cost for health benefits coverage. An employee or family member cannot be covered under more than one DCEHB enrollment.			
Coverage Tier:		Health Plan:	
☐ Employee Only ☐ Employee + 1 ☐ Employee & Family		☐ Kaiser Permanente- HMO ☐ United Healthcare Nationwide	
☐ I Waive Health Coverage ☐ Check here if you are enrolling a Domestic Partner		☐ Aetna - CDHP ☐ Aetna - HMO ☐ Aetna - PPO	

3 Dental & Optical Insurance (Non-Union Employees ONLY): DCEHB provides coverage for full-time and part time benefits eligible employees. An employee or family member cannot be covered under more than one DCEHB enrollment. NOTE: Union employees must connect with their union to ensure coverage. This form will not guarantee coverage for union employees.			
Coverage Tier:		Optical Plan:	Dental Plan:
☐ Employee Only ☐ Employee & Family ☐ Check here if you are enrolling a Domestic Partner		☐ Quality Plan Administrators ☐ I Waive Optical Coverage	☐ Cigna DHMO ☐ Cigna PPO ☐ I Waive Dental Coverage

4 Dependents: List all dependents (not including yourself) to be covered by this enrollment. Coverage is available to dependent children up to age 26. * 1=Spouse 2=Son 3=Daughter 4=Domestic Partner (Domestic Partners must meet the requirements of 29 DCMR 8001.1)						
Name	Relationship*	Gender	Date of Birth	SSN	Full Time College Student?	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	

5 Flexible Spending Accounts: DCEHB provides coverage for full-time and part- time benefits eligible employees. This program is administered by Benefits Resource, Inc.			
☐ I wish to participate in the Healthcare Account by electing \$ _____ (Minimum \$100.00 - Maximum \$2,500.00 per calendar year)	☐ I wish to participate in the Dependent Care Account by electing \$ _____ (Minimum \$100.00 - Maximum \$5,000.00 per calendar year)		
☐ I wish to participate in the Commuter Pre-Tax Transit Plan by electing \$ _____ (Maximum \$255.00 per month/\$3,060.00 per calendar year)	☐ I wish to participate in the Commuter Pre-Tax Parking Plan by electing \$ _____ (Maximum \$255.00 per month/\$3,060.00 per calendar year)		
6 Short Term Disability	☐ Voluntary ST Disability	7 Long Term Disability	☐ Voluntary LT Disability

8 Life Insurance: DCEHB provides coverage for full-time and part- time benefits eligible employees. Employees pay a share of the cost for basic coverage and the full cost for optional coverage.				
Waiver of All Coverage ☐ I want no life insurance coverage at all. I understand that my decision to waiver coverage now will affect my ability to enroll at a later date.	Basic Life ☐ I want the Basic Life Insurance. NOTE: If you do not elect Basic Life, you may not elect Option A, B or C.	Option A Standard ☐ I want the Standard \$10,000 optional insurance.	Option B - Additional ☐ I want the Additional optional insurance in the multiple of my annual basic pay I indicate below by marking "X" in the appropriate box. ☐ 1 times my pay ☐ 4 times my pay ☐ 2 times my pay ☐ 5 times my pay ☐ 3 times my pay	Option C – Family Coverage ☐ I want the Family optional insurance. In the event of their death I would receive: ☐ 10K- Dependent ☐ 10K- Dependent - 10K Spouse ☐ 10K- Dependent - 25K -Spouse ☐ 10K- Dependent - 50K-Spouse

In making this election I understand that: I cannot change or revoke this compensation reduction agreement at anytime 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 hire date to submit my initial enrollment form and 31 to 60 days from the date of any qualifying event to make these elections.

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 the applicant provided false information materially related to a claim.

Employee Signature:		Date:	
DC Public Schools			
Agency	Signature of Authorized Agency Official	Date Processed	Effective Date