



DISTRICT OF COLUMBIA EMPLOYEES BENEFITS ENROLLMENT REGISTRATION FORM

2017 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: DCPS 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.
Coverage Tier: Health Plan:
Employee Only Employee + 1 Employee & Family
I Waive Health Coverage Check here if you are enrolling a Domestic Partner
Aetna - CDHP Aetna - HMO Aetna - PPO
Kaiser Permanente- HMO United Healthcare Nationwide

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)
Table with columns: Name, Relationship*, Gender, Date of Birth, SSN, Full Time College Student? (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 \$2,600.00 per calendar year)
I wish to participate in the Dependent Care Account by electing \$ (Min.\$100.00 – Max. \$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 Basic Life Option A Standard Option B - Additional Option C - Family Coverage
I want no life insurance coverage at all. I understand that my decision to waive coverage now will affect my ability to enroll at a later date.
I want the Basic Life Insurance. NOTE: If you do not elect Basic Life, you may not elect Option A, B or C.
I want the Standard \$10,000 optional insurance.
I want the Additional optional insurance in the multiple of my annual basic pay I indicate below by marking "X" in the appropriate box.
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 any time during the year for which this election is made (except for FSA Commuter Plans), 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) or loss or gain of other coverage. 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.

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