



DISTRICT OF COLUMBIA EMPLOYEES HEALTH BENEFITS PROGRAM

REGISTRATION FORM

(Please Read Instructions) — (Use typewriter or print with ball-point pen, bearing down to make legible copies.)

☐ New Enrollment ☐ Change ☐ Temporary Continuance of Coverage

PART A

1. Name (Last) First (Middle Initial)	2. Date of Birth (Use Numbers) Month Day Year	3. Are You Now Married ☐ Yes ☐ No
4. Your Mailing Address (Number and Street) (City) (State) (Zip Code)	5. Social Security Number - - - - -	6. Sex ☐ Male ☐ Female
7. Work Phone ()		8. Home Phone ()

IMPORTANT—An employee or family member cannot be covered under more than one DCEHB enrollment. If you are already covered through the family enrollment of another District of Columbia employee or annuitant, you must register not to enroll or the other enrollment must be cancelled or changed to Self Only. Similarly, if a family member listed by you in Part B is covered through his or her own enrollment, you cannot elect a family enrollment unless the family cancels his or her enrollment.

PART B

1. I elect to enroll in a health benefits plan as shown below. I authorize deductions from my salary or compensation to cover my share of the cost of the enrollment.							
Name of Plan		HMO Facility to be used (if applicable)		Enrollment Code			
Type of Enrollment ☐ Self Only ☐ Self and Family		Primary Care Physician Code Number - - - - -		- - - - -			
2. In the space below list all eligible family members without exception. List spouse first, then your unmarried dependent children and dates of birth (DOB). Do not list parents or others who are not eligible family members. They will not receive benefits even if listed.							
Names of Family Members	Social Security No.	DOB	Sex	Names of Family Members	Social Security No.	DOB	Sex
a.			M F	d.			M F
b.			M F	e.			M F
c.			M F	f.			M F

PART C

Answer items 1, 2, 3, and 4 to show Plan and Enrollment Code being changed and eligibility for change			
1. Present Plan Name	2. Present Plan Enrollment Code - - - - -	3. Number of event that Permits Change (See Instruction Table)	4. Date of Event that Permits Change Month Day Year

PART D

Place an "X" in the box in item 1 or 2, whichever applies.			
1. I elect not to enroll under the D.C. Employees Health Benefits Program. ☐	2. I elect to cancel my present enrollment under the code shown below. ☐	My signature in Part F, item 1, certifies that I have read "Cancellation of Enrollment" on the instructions.	Present Enrollment Code - - - - -

PART E

1. Do you, your spouse or any other eligible family members have any group health insurance coverage? (Not including any enrollment made on this form.) ☐ Yes (Complete A & B) ☐ No	a. Name of Insurance Company (Champus, Medicare, FEHB, DCEHB, or other non-District Plan, etc.)	b. Name of Policyholder
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PART F

1. Your Signature (Do Not Print)	2. Date
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PART G

1. Name and Address (including Zip Code) of Servicing Personnel Office	2. Date Received in Servicing Personnel Office.	3. Effective Date of Election
	4. Effective Date of Termination of Enrollment Shown in Part C.	5. Health Plan Report No.
6. Signature of Authorized Agency Official	7. Payroll Office No.	8. Insurance Group No.
	9. Compensation Unit Code (Subgroup No.)	10. Pay Group (Circle One) 01 02 06

REMARKS (For use only by agency)

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Warning—Making a false statement on this form is punishable by criminal penalties pursuant to D.C. Code 22-2514 (1981). You may be subject to a \$1,000 fine or prison for not more than 1 year or both.

TIME LIMIT FOR ENROLLMENT — 31 DAYS OR TIME LIMIT SHOWN ON BACK OF COPY 1.

White Copy — Official Personnel Folder
Yellow Copy — Payroll OfficeBlue Copy — New Carrier
Pink Copy — Employee's CopyGreen Copy — Old Carrier
Gold Copy — Managed CareD.C. Office of Personnel
D.C. Standard Form 1269
(Rev. 9/94) 6-0004-1 wd-422

TABLE OF PERMISSIBLE CHANGES IN ENROLLMENT OF EMPLOYEES

Enrollment May Be Cancelled or Changed from Family to Self Only at Any Time

No.	Events That Permit Enrollment or Change Event	Change Permitted			Time Limit in Which Registration Form Electing Change Must be Filed With Employing Office
		From Not Enrolled to Enrolled	From Self Only to Family	From One Plan or Option to Another	
1.	Open Season	Yes	Yes	Yes	As announced by the D.C. Office of Personnel.
2.	Change in marital status (marriage, divorce, annulment, death of spouse).	Yes	Yes	Yes	From 31 days before to 60 days after change in marital status.
3.	Other change in family status (for example, birth of a child, legal separation, discharge from military service of a spouse or of a child under age 22).	No	Yes	No	Within 60 days after change in family status.
4.	Employee, covered as family member of another under DCEHB, loses coverage other than by cancellation or change to Self Only of the covering enrollment; or employee, covered under Retired D.C. Health Benefits Program or under another District-sponsored health benefits program, loses such coverage for any reason.	Yes	Does Not Apply	Does Not Apply	With 60 days after the effective date of termination by death of the person enrolled; within 31 days for other reasons.
5.	Employee, covered as a family member of another under DCEHB, loses coverage because of change in the covering enrollment from Family to Self Only.	Yes, for Self Only	Does Not Apply	Does Not Apply	Within 31 days after change of covering enrollment has been filed.
6.	Return to active civilian duty from military service which was not limited to 30 days or less.	Yes	Yes	Yes	Within 31 days after return to active civilian duty.
7.	Termination of plan (under this Program) in which enrolled.	Does Not Apply	Yes	Yes	As set by the D.C. Office of Personnel.
8.	Self Only enrollment under this Program of employee's spouse terminates as a result of change in spouse's District employment status or 365 days nonpay status.	No	Yes	No	Within 31 days after termination of spouse's enrollment.
9.	Employee who is not enrolled loses coverage under parent's non-District health plan, or employee covered by parent's enrollment under DCEHB loses coverage on reaching age 22.	Yes	Does Not Apply	Does Not Apply	Within 60 days after loss of coverage because of parent's death; within 31 days after loss of coverage for other reasons.
10.	Enrolled employee becomes eligible for Medicare.	Does Not Apply	No	Yes	At any time after 31 days before becoming eligible for Medicare.
11.	Employee's eligible child (or children) loses coverage under another enrollment under the DCEHB, FEHB, or non-District health plan, other than if the enrolled person voluntarily cancels or drops the DCEHB, FEHB, or non-District plan.	No	Yes	No	Within 31 days after child's (children's) loss of coverage.
12.	Employee loses coverage under Medicaid.	Yes	Does Not Apply	Does Not Apply	Within 31 days after termination of Medicaid.
13.	Employee, covered as a family member of another under DCEHB or FEHB, loses coverage due to cancellation of the covering enrollment.	Yes	Does Not Apply	You must enroll in the same plan and option as that from which coverage is lost, if eligible to enroll in that plan, within 31 days after the cancellation of the covering enrollment. If not eligible to enroll in that plan, you may enroll in any available plan within the 31-day period.	
14.	Employee or spouse loses coverage under employee's or spouse's non-District health plan, other than if the enrolled person voluntarily cancels or drops the non-District health plan.	Yes	Yes	No	Within 31 days before or after move.
15.	Former spouses who are eligible to enroll under the authority of the D.C. Spouse Equity Act (D.C. Law 7-214).	Yes	Does Not Apply	Does Not Apply	Generally within 60 days of the divorce.
16.	Employee separated from service and eligible for temporary continuance of coverage.	Does Not Apply	Yes	Yes	Within 60 days after the later of: separation; or receiving notice of the opportunity to elect temporary continuation of coverage. Coverage is effective the day after other DCEHB coverage ends, including the 31-day extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be retroactive.
17.	Child of employee, former employee or annuitant stops meeting the requirements for unmarried dependent children.	Yes*	Does Not Apply	Does Not Apply	Within 60 days after the later of: the qualifying event; or the child's receiving notice of the opportunity to select temporary continuance of coverage (based on the enrollee's notification to the employing office of the child's eligibility). Coverage is effective the day after other DCEHB coverage ends, including the 31-day extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be retroactive.

* Individuals must be otherwise eligible to enroll.

EFFECTIVE DATES

Enrollments and changes in enrollment (except cancellations and open season changes) become effective on the first day of the first pay period after one in which (1) the Servicing Personnel Office receives the registration form (DCSF 1269), and that (2) follows a pay period during any part of which the employee was in a pay status. (The pay status requirement does not apply to a change from Self and Family to Self Only or a change from Self Only to Self and Family due to the birth of a child or addition of a child as a new family member.) A cancellation becomes effective on the last day of the pay period after the pay period in which the Servicing Personnel Office receives the DCSF 1269.