FEHB
Federal Employees Health Benefits Program

# Health Benefits Election Form

Form Approved:
OMB No. 3206-0141

## Who May Use OPM Form 2809

- Annuitants
- Survivor annuitants
- Former spouses
- Children and former spouses who are eligible for temporary continuation of coverage

## Instructions for Completing OPM 2809

*Type or print firmly. We have not provided instructions for those items that require no further explanation.*

### *Part A — Enrollee and Family Member Information.*

You must complete this part.

Item 2. See the Privacy Act and Public Burden Statements on page 4.

Item 5. If you are separated but not divorced, you are still married.

Item 7. If you have Medicare, show which Parts you have. Also indicate whether you have prescription drug coverage under the Medicare Part D Program.

Item 8. TRICARE is a health care program for active duty and retired members of the uniformed services, their families, and survivors. This includes TRICARE for Life for members age 65 and older.

Item 9. If you have other group insurance (private, state, Medicaid, Peace Corps, CHAMPVA), check the box.

Item 10. Write the name of any other insurance you have.

Complete information for family members only if your enrollment is for Self and Family. (If you need extra space for additional family members, list them on a separate sheet and attach.)

Item 13. Please provide Social Security numbers for your dependents, if available. If not available, leave blank; benefits will not be withheld. (See Privacy Act Statement on page 4.)

Item 16. Provide the code which indicates the relationship of each eligible family member to you.

| Code | Family Relationship |
|---|---|
| 01 | Spouse |
| 19 | Unmarried dependent child under age 26 |
| 09 | Adopted Child |
| 17 | Stepchild |
| 10 | Foster Child |
| 99 | Unmarried disabled child over age 26 incapable of self-support because of a physical or mental disability that began before age 26. |

Item 18. If a family member has Medicare, show which Parts he/she has on the line with his/her name. Check D if the family member has prescription drug coverage under the Medicare Part D Program.

Item 19. If a family member has TRICARE (see item 8), check the box.

Item 20. If a family member has other group insurance (private, state, Peace Corps, Medicaid), check the box.

Item 21. Give the name of any other insurance this family member has.

#### Family Members Eligible for Coverage

Unless you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment include your spouse and your unmarried dependent children under age 26. Eligible children include your legitimate or adopted children and recognized natural children, stepchildren or foster children, if they live with you in a regular parent-child relationship. A recognized natural child also may be included if a judicial determination of support has been obtained or you show that you provide regular and substantial support for the child.

Other relatives (for example, your parents) are ***not*** eligible for coverage even if they live with you and are dependent upon you.

- If you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment are the unmarried dependent natural or adopted children under age 26 of both you and your former or deceased spouse.
- Children whose marriage ends before they reach age 26 become eligible for coverage under your Self and Family enrollment from the date the marriage ends until they reach age 26.

In some cases, an unmarried, disabled child age 26 or older is eligible for coverage under your Self and Family enrollment if you provide adequate medical certification of a mental or physical handicap that existed before his or her 26th birthday and renders the child incapable of self-support.

***Note:*** *The Office of Personnel Management can give you additional details about family member eligibility including any certification or documentation that may be required for coverage.*

### *Part B — Present Plan.*

You must complete this part if you are changing, canceling, or suspending your enrollment.

Item 1. Enter the name of the plan you are enrolled in, as shown on the front cover of the plan brochure.

Item 2. Enter the enrollment code of the plan.

### *Part C — New Plan.*

Complete this part to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.

Items 1 and 2. Enter the plan name and enrollment code as shown on the front cover of the brochure of the plan you want to be enrolled in. The enrollment code shows the plan and option you are electing and whether you are enrolling for Self Only or Self and Family.

To enroll in a Health Maintenance Organization (HMO), you must live in the geographic area specified by the carrier.

To enroll in an employee organization plan, you must be or become a member of the plan's sponsoring organization, as specified by the carrier.

Your signature in Part F authorizes deductions from your annuity to cover your cost of the enrollment you elect in this item, unless you are required to make direct payments.

### *Part D — Event Code.*

Item 1. Enter the event code that permits you to enroll, change, or cancel. (See the Table of Permissible Changes in Enrollment starting on page 5.)

**Explanation of Table of Permissible Changes in Enrollment**

The tables on pages 5 through 7 illustrate when an annuitant, former spouse, or person eligible for Temporary Continuation of Coverage (TCC) may enroll or change enrollment. The tables show those permissible events that are found in FEHB regulations at 5 CFR Part 890.

The tables have been organized by enrollee category. Each category is designated by a number to identify the enrollee group, as follows:

2 Annuitants

3 Former spouses eligible for coverage under the Spouse Equity provisions of FEHB law.

4 TCC enrollees.

Following each number is a letter which identifies a specific permissible event; for example, the event code 2A refers to open season.

Item 2. Enter the date of the permissible event using numbers to show month, day, and complete year; e.g., 06/30/2011. If you are electing to enroll, enter the date you became eligible to enroll (for example, the date your annuity was restored). If you are making an open season enrollment or change, enter the date on which the open season begins.

### *Part E — Suspension/Cancellation.*

Check a box only if you wish to suspend or cancel your FEHB enrollment. Also enter your present enrollment code in Part B.

You may suspend your FEHB enrollment because you are enrolling in one of the following programs:

- A Medicare HMO or Medicare Advantage plan,
- Medicaid or similar State-sponsored program of medical assistance for the needy,
- TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life),
- Peace Corps, or
- CHAMPVA

You can reenroll in the FEHB Program if your other coverage ends. If your coverage ends ***involuntarily***, you can reenroll 31 days before through 60 days after loss of coverage. If you want to reenroll in the FEHB Program for a reason other than an involuntary loss of coverage, you may do so during the next open season.

You must submit documentation of eligibility for coverage under the non-FEHB Program to the Office of Personnel Management.

Initial the last box only if you wish to cancel your FEHB enrollment. Also enter your present enrollment code in Part B. *Be sure to read the information below in the paragraph titled* ***"Annuitants Who Cancel Their Enrollment."***

**Annuitants Who Cancel Their Enrollment**

Generally, you cannot reenroll as an annuitant unless you are continuously covered as a family member under another person's enrollment in the FEHB Program during the period between your cancellation and reenrollment. OPM can advise you on events that allow eligible annuitants to reenroll. If you cancel your enrollment because you are covered under another FEHB enrollment, you can reenroll from 31 days before through 60 days after you lose that coverage under the other enrollment.

***If you cancel your enrollment for any other reason, you cannot reenroll later, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.***

**Former Spouses (Spouse Equity) Who Cancel Their Enrollment**

Generally, if you cancel your enrollment in the FEHB Program, you cannot reenroll as a former spouse. However, if you stop the enrollment because you acquire other FEHB coverage, your right to FEHB coverage under the Spouse Equity provisions continues. You may reenroll as a former spouse from 31 days before through 60 days after you lose coverage under the other FEHB enrollment.

***If you cancel your enrollment for any other reason, you cannot reenroll later, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.***

### *Part F — Signature.*

Your retirement system cannot process your request unless you complete this part.

If you are registering for someone else under a written authorization from that person to do so, sign your name in Part F and attach the written authorization.

If you are registering as the court-appointed guardian for a former spouse eligible for coverage under the Spouse Equity provisions or for an individual eligible for TCC, sign your name in Part F and attach evidence of your court-appointed guardianship.

### Dual Enrollment

Generally, you cannot be covered as an annuitant under your own enrollment and as a family member under someone else's enrollment in the Federal Employees Health Benefits (FEHB) Program. However, such dual enrollments may be permitted under certain circumstances in order to:

- Protect the interests of children who otherwise would lose coverage as family members or
- Enable an employee who is under age 26 and covered under a parent's enrollment and who becomes the parent of a child to enroll for Self and Family coverage.

No person (enrollee or family member) is entitled to receive benefits under more than one enrollment in the Program. (Each enrollee must notify his or her plan of the names of the persons to be covered under his or her enrollment who are not covered under the other enrollment.)

### Enrollment in an HMO (Prepaid) Plan

To enroll in an HMO plan, you must live in the plan's enrollment area as stated in the plan brochure.

### Enrollment in a Fee-for-Service Plan

If you enroll in a fee-for-service plan sponsored by an employee organization, you must be (or become) a member of the organization that sponsors the plan. Your membership will be verified.

### Self Only Enrollment

A Self Only enrollment provides benefits just for you.

### Self and Family Enrollment

A Self and Family enrollment provides benefits for you and your family as described on page 1.

If your present enrollment is Self Only, you must change to a Self and Family enrollment if you want to provide coverage for a new eligible family member. See the table starting on page 5 for events which allow you to change to a Self and Family enrollment.

### Changes in Enrollment

After the Office of Personnel Management (OPM) processes your request to enroll or change your enrollment, OPM will send you written confirmation. Your health plan will mail a new identification (I.D.) card to you as soon as possible. (OPM does not issue I.D. cards.) If you should need health services before you receive your new I.D. card, show the written confirmation you receive from OPM to the doctor or hospital. They can then verify your new coverage with the plan.

### Suspension or Cancellation of Enrollment

You may suspend or cancel your enrollment at any time for one of several reasons.

If you cancel your enrollment because you are going to be continuously covered as a family member under another person's FEHB enrollment during the period between your cancellation and reenrollment, you will be eligible to reenroll when you lose coverage under that family member's enrollment.

If you suspend your FEHB Program enrollment to be covered by a Medicare Advantage plan, Medicaid or a similar State-sponsored program of medical assistance for the needy, TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), Peace Corps, or CHAMPVA, you will be eligible to enroll in the FEHB Program if any of the above coverage ends.

### Reenrollment Eligibility

If you cancel or suspend your enrollment as described above, you may voluntarily reenroll in the FEHB Program during an annual open season.

If you involuntarily lose your Medicare Advantage plan, Medicaid or a similar State-sponsored plan, TRICARE, Peace Corps, or CHAMPVA coverage, you can reenroll in the FEHB Program effective the day after your coverage ends. Your request to reenroll must be received at OPM within the period beginning 31 days before and ending 60 days after your coverage ends. Otherwise, you must wait until open season to reenroll.

If you cancel your Federal Employees Health Benefits (FEHB) enrollment, you cannot later reenroll, and you and any family members will not be entitled to a temporary extension of coverage or conversion to individual coverage. Former spouses who cancel can never reenroll as former spouses.

### Effective Dates of Changes

1. Open Season changes for annuitants take effect January 1.
2. Non-Open Season changes (except cancellations) take effect the first day of the month following the month in which the Office of Personnel Management (OPM) receives your OPM Form 2809. ***Note:*** 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 is effective the first day of the month in which the child is born or becomes an eligible family member.
3. ***Cancellations:*** Your cancellation will take effect the end of the month in which OPM receives your completed OPM Form 2809.

### Future Changes in Your Status

When your home or mailing address changes, you need to notify the Office of Personnel Management immediately. Call our toll-free number 1-888-767-6738 (TTY: 1-800-878-5707). Or, write to the Change-of-Address Section, P.O. Box 440, Boyers, PA 16017-0440. Be sure to include your new address, your name, and your retirement claim number. You also need to notify your health benefits plan. If the family member(s) covered by your health benefits enrollment change, you must inform your health benefits plan. **You must notify the Office of Personnel Management immediately if you become the only person covered by a Self and Family enrollment so that your enrollment can be changed to Self Only.** You must also inform the Office of Personnel Management if you change your name or add family members.

**For more information call our toll-free number 1-888-767-6738, write to us, visit our web site, or send email.**

Mailing Address: Office of Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017-0045

Web site: http://www.opm.gov/retire

Email: retire@opm.gov

## Privacy Act and Public Burden Statements

The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program under Chapter 89, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency. While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB Program. Executive Order 9397 (November 22, 1943) allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

We estimate this form takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, Retirement Services Publications Team, (3206-0141), Washington, D.C. 20415-3430. The OMB number 3206-0141 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

## Tables of Permissible Changes in FEHB Enrollment

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

| ***Events That Permit Enrollment or Change*** | | ***Change Permitted*** | | | ***Time Limits*** |
|---|---|---|---|---|---|
| *Code* | *Event* | *From Not Enrolled to Enrolled* | *From Self Only to Self and Family* | *From One Plan or Option to Another* | *When You Must File Health Benefits Election Form With the Office of Personnel Management* |
| **2** | **Annuitant/Survivor Annuitant**<br><br>***Note for enrolled survivor annuitants:*** A change in family status based on additional family members can only occur if the additional eligible family members are family members of the deceased employee or annuitant. | | | | |
| 2A | Open Season | No | Yes | Yes | As announced by OPM. |
| 2B | Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce.<br>*Note: Survivors cannot change plans because of the death of the annuitant.* | No | Yes | Yes | From 31 days before through 60 days after the event. |
| 2C | Reenrollment of annuitant who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid or similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan and TRICARE for Life), Peace Corps, or CHAMPVA, and who later **involuntarily** loses this coverage under one of these programs. | May reenroll | N/A | N/A | From 31 days before through 60 days after involuntary loss of coverage. |
| 2D | Reenrollment of annuitant who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid or similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), Peace Corps, or CHAMPVA, and who wants to reenroll in the FEHB Program for any reason other than an involuntary loss of coverage. | May reenroll | N/A | N/A | During open season. |
| 2E | Restoration of annuity payments; for example:<br>• Disability annuitant who was enrolled in FEHB, and whose annuity terminated due to restoration of earning capacity or recovery from disability, and whose annuity is restored;<br>• Surviving spouse who was covered by FEHB immediately before survivor annuity terminated because of remarriage and whose annuity is restored;<br>• Surviving child who was covered by FEHB immediately before survivor annuity terminated because student status ended and whose survivor annuity is restored;<br>• Surviving child who was covered by FEHB immediately before survivor annuity terminated because of marriage and whose survivor annuity is restored. | Yes | N/A | N/A | Within 60 days after the retirement system mails a notice of insurance eligibility. |
| 2F | Annuitant or eligible family member loses FEHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment. | Yes | Yes | Yes | From 31 days before through 60 days after date of loss of coverage. |
| 2G | Annuitant or eligible family member loses coverage under FEHB or another group insurance plan; for example:<br>• Loss of coverage under another federally-sponsored health benefits program;<br>*Note: Annuitants who previously suspended FEHB to use a Medicare Advantage Plan, TRICARE, Peace Corps, or CHAMPVA, see codes 2C and 2D.*<br>• Loss of coverage under Medicaid or similar State-sponsored program;<br>*Note: Annuitants who previously suspended FEHB to use Medicaid or a similar State-sponsored program, see codes 2C and 2D.*<br>• Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan;<br>• Loss of coverage under a non-Federal health plan. | No | Yes | Yes | From 31 days before through 60 days after loss of coverage. |

| Events That Permit Enrollment or Change | | Change Permitted | | | Time Limits |
|---|---|---|---|---|---|
| *Code* | *Event* | *From Not Enrolled to Enrolled* | *From Self Only to Self and Family* | *From One Plan or Option to Another* | *When You Must File Health Benefits Election Form With the Office of Personnel Management* |
| 2H | Annuitant or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan. | N/A | Yes | Yes | During open season, unless OPM sets a different time. |
| 2I | Annuitant or covered family member in a Health Maintenance Organization (HMO) moves outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves further from this area. | N/A | Yes | Yes | When you or a family member notify OPM of a change of address outside the plan's service area. |
| 2J | Employee in an overseas post of duty retirees or dies. | No | Yes | Yes | Within 60 days after retirement or death. |
| 2K | An enrolled annuitant separates from duty after serving 31 days or more in a uniformed service. | N/A | Yes | Yes | Within 60 days after separation from the uniformed service. |
| 2L | On becoming eligible for Medicare.<br><br>(This change may be made only once in a lifetime.) | N/A | No | Yes | At any time beginning on the 30th day before becoming eligible for Medicare. |
| 2M | Annuity is not sufficient to make withholdings for plan in which enrolled. | N/A | No | Yes | OPM will advise annuitant of the options. |
| **3** | **Former Spouse Under The Spouse Equity Provisions**<br><br>***Note:*** Former spouse may change to Self and Family only if family members are also eligible family members of the annuitant. | | | | |
| 3A | Initial opportunity to enroll. Former spouse must be eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615), as amended, the Intelligence Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204). | Yes | N/A | N/A | Generally, must **apply** within 60 days after dissolution of marriage. However, if a retiring employee elects to provide a former spouse annuity or insurable interest annuity for the former spouse, the former spouse must apply within 60 days after OPM's notice of eligibility for FEHB. May **enroll** any time after OPM establishes eligibility. |
| 3B | Open Season. | No | Yes | Yes | As announced by OPM. |
| 3C | Change in family status based on addition of family members who are also eligible family members of the annuitant. | No | Yes | Yes | From 31 days before through 60 days after change in family status. |
| 3D | Reenrollment of former spouse who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid or similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), Peace Corps, or CHAMPVA, and who later **involuntarily** loses this coverage under one of these programs. | May reenroll | N/A | N/A | From 31 days before through 60 days after involuntary loss of coverage. |
| 3E | Reenrollment of former spouse who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid or similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), Peace Corps, or CHAMPVA, and who wants to reenroll in the FEHB Program for any reason other than an involuntary loss of coverage. | May reenroll | N/A | N/A | During open season. |
| 3F | Former spouse or eligible child loses FEHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment. | Yes | Yes | Yes | From 31 days before through 60 days after date of loss of coverage. |

| Events That Permit Enrollment or Change | | Change Permitted | | | Time Limits |
|---|---|---|---|---|---|
| *Code* | *Event* | *From Not Enrolled to Enrolled* | *From Self Only to Self and Family* | *From One Plan or Option to Another* | *When You Must File Health Benefits Election Form With the Office of Personnel Management* |
| 3G | Enrolled former spouse or eligible child loses coverage under FEHB or another group insurance plan; for example:<br>• Loss of coverage under another federally-sponsored health benefits program;<br>*Note: Former spouses who previously suspended FEHB to use a Medicare Advantage plan, TRICARE, Peace Corps, or CHAMPVA, see codes 3D and 3E.*<br>• Loss of coverage under Medicaid or similar State-sponsored program;<br>*Note: Former spouses who previously suspended FEHB to use Medicaid or a similar State-sponsored program, see codes 3D and 3E.*<br>• Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan;<br>• Loss of coverage under a non-Federal health plan. | N/A | Yes | Yes | From 31 days before through 60 days after loss of coverage. |
| 3H | Former spouse or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan. | N/A | Yes | Yes | During open season, unless OPM sets a different time. |
| 3I | Former spouse or covered family member in a Health Maintenance Organization (HMO) moves outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves further from this area. | N/A | Yes | Yes | When you or a family member notify OPM of a change of address outside the plan's service area. |
| 3J | On becoming eligible for Medicare<br><br>(This change may be made only once in a lifetime.) | N/A | No | Yes | At any time beginning the 30th day before becoming eligible for Medicare. |
| 3K | Former spouse's annuity is not sufficient to make FEHB withholdings for plan in which enrolled. | No | No | Yes | Retirement system will advise former spouse of options. |
| **4** | **Temporary Continuation of Coverage (TCC) For Eligible Former Spouses and Children.**<br><br>***Note:*** Former spouse may change to Self and Family only if family members are also eligible family members of the annuitant. | | | | |
| 4A | Opportunity to enroll for continued coverage under TCC provisions:<br>• Former spouse<br>• Child who ceases to qualify as a family member | <br>Yes<br>Yes | <br>N/A<br>N/A | <br>N/A<br>N/A | Within 60 days after the qualifying event, or receiving notice of eligibility, whichever is later. |
| 4B | Open Season:<br>• Former spouse<br>• Child who ceases to qualify as a family member | <br>No<br>No | <br>Yes<br>Yes | <br>Yes<br>Yes | As announced by OPM. |
| 4C | Change in family status (except former spouse); for example, marriage, birth or death of family member, adoption, legal separation, or divorce. | No | Yes | Yes | From 31 days before through 60 days after event. |
| 4D | Change in family status of former spouse, based on addition of family members who are eligible family members of the employee or annuitant. | No | Yes | Yes | From 31 days before through 60 days after event. |
| 4E | Reenrollment of a former spouse or child whose TCC enrollment was terminated because of other FEHB coverage and who loses the other FEHB coverage before the TCC period of eligibility (18 or 36 months) expires. | May reenroll | N/A | N/A | From 31 days before through 60 days after the event. Enrollment is retroactive to the date of the loss of the other FEHB coverage. |

| Events That Permit Enrollment or Change | | Change Permitted | | | Time Limits |
|---|---|---|---|---|---|
| *Code* | *Event* | *From Not Enrolled to Enrolled* | *From Self Only to Self and Family* | *From One Plan or Option to Another* | *When You Must File Health Benefits Election Form With the Office of Personnel Management* |
| 4F | Enrollee or eligible family member loses coverage under FEHB or another group insurance plan; for example:<br>• Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment (but see event 4E);<br>• Loss of coverage under another federally-sponsored health benefits program;<br>• Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan;<br>• Loss of coverage under Medicaid or similar State-sponsored program;<br>• Loss of coverage under a non-Federal health plan. | No | Yes | Yes | From 31 days before through 60 days after loss of coverage. |
| 4G | Enrollee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan. | N/A | Yes | Yes | During open season, unless OPM sets a different time. |
| 4H | Enrollee or covered family member in a Health Maintenance Organization (HMO) moves outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves further from this area. | N/A | Yes | Yes | When you or a family member notify OPM of a change of address outside the plan's service area. |
| 4I | On becoming eligible for Medicare.<br><br>(This change may be made only once in a lifetime.) | N/A | No | Yes | At any time beginning on the 30th day before becoming eligible for Medicare. |

FEHB
Federal Employees
Health Benefits Program

# Health Benefits Election Form

For Use By Annuitants and Former Spouses of Annuitants

Form Approved:
OMB No. 3206-0141

## Part A - Enrollee and Family Member Information *(for additional family members attach a separate sheet)*

| 1. Enrollee name *(last, first, middle initial)* | 2. Social Security Number | 3. Date of birth _ _ / _ _ / _ _ _ _ | 4. Sex ☐ M ☐ F | 5. Are you married? ☐ Yes ☐ No |
|---|---|---|---|---|
| 6. Mailing address *(including ZIP Code)* | | 7. Medicare ☐ A ☐ B ☐ D | 8. TRICARE ☐ | 9. Other insurance ☐ |
| | | 10. Name of insurance | | 11. Insurance policy no. |
| 12. Name of family member *(last, first, middle initial)* | 13. Social Security Number | 14. Date of birth _ _ / _ _ / _ _ _ _ | 15. Sex ☐ M ☐ F | 16. Relationship code |
| 17. Address *(if different from enrollee)* | | 18. Medicare ☐ A ☐ B ☐ D | 19. TRICARE ☐ | 20. Other insurance ☐ |
| | | 21. Name of insurance | | 22. Insurance policy no. |
| Name of family member *(last, first, middle initial)* | Social Security Number | Date of birth _ _ / _ _ / _ _ _ _ | Sex ☐ M ☐ F | Relationship code |
| Address *(if different from enrollee)* | | Medicare ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐ |
| | | Name of insurance | | Insurance policy no. |
| Name of family member *(last, first, middle initial)* | Social Security Number | Date of birth _ _ / _ _ / _ _ _ _ | Sex ☐ M ☐ F | Relationship code |
| Address *(if different from enrollee)* | | Medicare ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐ |
| | | Name of Insurance | | Insurance policy no. |

| Part B - Present Plan | | Part C - New Plan | | Part D - Event Code | |
|---|---|---|---|---|---|
| 1. Plan name | 2. Enrollment code | 1. Plan name | 2. Enrollment code | 1. Event code | 2. Date of event _ _ / _ _ / _ _ _ _ |

## Part E - Election to Suspend/Cancel *(fill in this part if you wish to suspend/cancel your enrollment in the FEHBP. See page 2 of the instructions.)*

I elect to suspend or cancel my enrollment and have initialed the appropriate box below.

| ☐ I will be covered under the FEHB enrollment of: | *Name* | *Social Security Number* |
|---|---|---|

☐ I am covered by a Medicare Advantage plan, Medicaid or a similar State-sponsored program of medical assistance for the needy. I am enclosing evidence of my coverage.

☐ I will be using CHAMPVA, TRICARE, or TRICARE for Life (enrollees over age 65 with Medicare Parts A and B). I am enclosing copies of my CHAMPVA authorization card or my Uniformed Services identification card and, if over age 65, my Medicare card showing Parts A and B.

☐ I am or will be covered by Peace Corps volunteer health benefits. I am enclosing evidence of my coverage.

☐ I am cancelling my enrollment for reasons other than the three situations shown above. **I understand I can never reenroll in the FEHBP.**

## Part F - Signature *(all who register or cancel must fill in this part)*

***WARNING:*** ***Any intentionally false statement on this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)***

| 1. Your signature *(do not print)* | 2. Telephone number | 3. Date *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _ | 4. Retirement Claim Number |
|---|---|---|---|

## Part G - To be Completed by OPM

| 1. Name and address | 2. Date received in OPM _ _ / _ _ / _ _ _ _ | 3. Effective date of action _ _ / _ _ / _ _ _ _ | 4. Payroll office number **24 90 0002** |
|---|---|---|---|
| **U.S. Office of Personnel Management**<br>**Retirement Services Programs**<br>**Washington, D.C. 20415** | 5. Signature of authorized agency official | | 6. Date _ _ / _ _ / _ _ _ _ |

**Remarks** *(For use by OPM only.)*

Federal Employees Health Benefits Program

# Health Benefits Election Form

For Use By Annuitants and Former Spouses of Annuitants

Form Approved: OMB No. 3206-0141

## Part A - Enrollee and Family Member Information *(for additional family members attach a separate sheet)*

| 1. Enrollee name *(last, first, middle initial)* | 2. Social Security Number | 3. Date of birth _ _ / _ _ / _ _ _ _ | 4. Sex ☐ M ☐ F | 5. Are you married? ☐ Yes ☐ No |
|---|---|---|---|---|
| 6. Mailing address *(including ZIP Code)* | | 7. Medicare ☐ A ☐ B ☐ D | 8. TRICARE ☐ | 9. Other insurance ☐ |
| | | 10. Name of insurance | | 11. Insurance policy no. |
| 12. Name of family member *(last, first, middle initial)* | 13. Social Security Number | 14. Date of birth _ _ / _ _ / _ _ _ _ | 15. Sex ☐ M ☐ F | 16. Relationship code |
| 17. Address *(if different from enrollee)* | | 18. Medicare ☐ A ☐ B ☐ D | 19. TRICARE ☐ | 20. Other insurance ☐ |
| | | 21. Name of insurance | | 22. Insurance policy no. |
| Name of family member *(last, first, middle initial)* | Social Security Number | Date of birth _ _ / _ _ / _ _ _ _ | Sex ☐ M ☐ F | Relationship code |
| Address *(if different from enrollee)* | | Medicare ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐ |
| | | Name of insurance | | Insurance policy no. |
| Name of family member *(last, first, middle initial)* | Social Security Number | Date of birth _ _ / _ _ / _ _ _ _ | Sex ☐ M ☐ F | Relationship code |
| Address *(if different from enrollee)* | | Medicare ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐ |
| | | Name of Insurance | | Insurance policy no. |

| Part B - Present Plan | | Part C - New Plan | | Part D - Event Code | |
|---|---|---|---|---|---|
| 1. Plan name | 2. Enrollment code | 1. Plan name | 2. Enrollment code | 1. Event code | 2. Date of event _ _ / _ _ / _ _ _ _ |

## Part E - Election to Suspend/Cancel *(fill in this part if you wish to suspend/cancel your enrollment in the FEHBP. See page 2 of the instructions.)*

I elect to suspend or cancel my enrollment and have initialed the appropriate box below.

| ☐ I will be covered under the FEHB enrollment of: | *Name* | *Social Security Number* |
|---|---|---|

☐ I am covered by a Medicare Advantage plan, Medicaid or a similar State-sponsored program of medical assistance for the needy. I am enclosing evidence of my coverage.

☐ I will be using CHAMPVA, TRICARE, or TRICARE for Life (enrollees over age 65 with Medicare Parts A and B). I am enclosing copies of my CHAMPVA authorization card or my Uniformed Services identification card and, if over age 65, my Medicare card showing Parts A and B.

☐ I am or will be covered by Peace Corps volunteer health benefits. I am enclosing evidence of my coverage.

☐ I am cancelling my enrollment for reasons other than the three situations shown above. **I understand I can never reenroll in the FEHBP.**

## Part F - Signature *(all who register or cancel must fill in this part)*

***WARNING:*** ***Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)***

| 1. Your signature *(do not print)* | 2. Telephone number | 3. Date *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _ | 4. Retirement Claim Number |
|---|---|---|---|

## Part G - To be completed by OPM

| 1. Name and address | 2. Date received in OPM _ _ / _ _ / _ _ _ _ | 3. Effective date of action _ _ / _ _ / _ _ _ _ | 4. Payroll office number **24 90 0002** |
|---|---|---|---|
| **U.S. Office of Personnel Management<br>Retirement Services Programs<br>Washington, D.C. 20415** | 5. Signature of authorized agency official | | 6. Date _ _ / _ _ / _ _ _ _ |

**Remarks** *(For use by OPM only.)*

Federal Employees Health Benefits Program

# Health Benefits Election Form

For Use By Annuitants and Former Spouses of Annuitants

Form Approved: OMB No. 3206-0141

## Part A - Enrollee and Family Member Information *(for additional family members attach a separate sheet)*

| 1. Enrollee name *(last, first, middle initial)* | 2. Social Security Number | 3. Date of birth _ _ / _ _ / _ _ _ _ | 4. Sex ☐ M ☐ F | 5. Are you married? ☐ Yes ☐ No |
|---|---|---|---|---|
| 6. Mailing address *(including ZIP Code)* | | 7. Medicare ☐ A ☐ B ☐ D | 8. TRICARE ☐ | 9. Other insurance ☐ |
| | | 10. Name of insurance | | 11. Insurance policy no. |
| 12. Name of family member *(last, first, middle initial)* | 13. Social Security Number | 14. Date of birth _ _ / _ _ / _ _ _ _ | 15. Sex ☐ M ☐ F | 16. Relationship code |
| 17. Address *(if different from enrollee)* | | 18. Medicare ☐ A ☐ B ☐ D | 19. TRICARE ☐ | 20. Other insurance ☐ |
| | | 21. Name of insurance | | 22. Insurance policy no. |
| Name of family member *(last, first, middle initial)* | Social Security Number | Date of birth _ _ / _ _ / _ _ _ _ | Sex ☐ M ☐ F | Relationship code |
| Address *(if different from enrollee)* | | Medicare ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐ |
| | | Name of insurance | | Insurance policy no. |
| Name of family member *(last, first, middle initial)* | Social Security Number | Date of birth _ _ / _ _ / _ _ _ _ | Sex ☐ M ☐ F | Relationship code |
| Address *(if different from enrollee)* | | Medicare ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐ |
| | | Name of Insurance | | Insurance policy no. |

| Part B - Present Plan | | Part C - New Plan | | Part D - Event Code | |
|---|---|---|---|---|---|
| 1. Plan name | 2. Enrollment code | 1. Plan name | 2. Enrollment code | 1. Event code | 2. Date of event _ _ / _ _ / _ _ _ _ |

## Part E - Election to Suspend/Cancel *(fill in this part if you wish to suspend/cancel your enrollment in the FEHBP. See page 2 of the instructions.)*

I elect to suspend or cancel my enrollment and have initialed the appropriate box below.

| ☐ I will be covered under the FEHB enrollment of: | *Name* | *Social Security Number* |
|---|---|---|

☐ I am covered by a Medicare Advantage plan, Medicaid or a similar State-sponsored program of medical assistance for the needy. I am enclosing evidence of my coverage.

☐ I will be using CHAMPVA, TRICARE, or TRICARE for Life (enrollees over age 65 with Medicare Parts A and B). I am enclosing copies of my CHAMPVA authorization card or my Uniformed Services identification card and, if over age 65, my Medicare card showing Parts A and B.

☐ I am or will be covered by Peace Corps volunteer health benefits. I am enclosing evidence of my coverage.

☐ I am cancelling my enrollment for reasons other than the three situations shown above. **I understand I can never reenroll in the FEHBP.**

## Part F - Signature *(all who register or cancel must fill in this part)*

***WARNING:*** ***Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)***

| 1. Your signature *(do not print)* | 2. Telephone number | 3. Date *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _ | 4. Retirement Claim Number |
|---|---|---|---|

## Part G - To be completed by OPM

| 1. Name and address | 2. Date received in OPM _ _ / _ _ / _ _ _ _ | 3. Effective date of action _ _ / _ _ / _ _ _ _ | 4. Payroll office number **24 90 0002** |
|---|---|---|---|
| **U.S. Office of Personnel Management**<br>**Retirement Services Programs**<br>**Washington, D.C. 20415** | 5. Signature of authorized agency official | | 6. Date _ _ / _ _ / _ _ _ _ |

**Remarks** *(For use by OPM only.)*

FEHB
Federal Employees
Health Benefits Program

# Health Benefits Election Form

For Use By Annuitants and Former Spouses of Annuitants

Form Approved:
OMB No. 3206-0141

## Part A - Enrollee and Family Member Information *(for additional family members attach a separate sheet)*

| 1. Enrollee name *(last, first, middle initial)* | 2. Social Security Number | 3. Date of birth _ _ / _ _ / _ _ _ _ | 4. Sex ☐ M ☐ F | 5. Are you married? ☐ Yes ☐ No |
|---|---|---|---|---|
| 6. Mailing address *(including ZIP Code)* | | 7. Medicare ☐ A ☐ B ☐ D | 8. TRICARE ☐ | 9. Other insurance ☐ |
| | | 10. Name of insurance | | 11. Insurance policy no. |
| 12. Name of family member *(last, first, middle initial)* | 13. Social Security Number | 14. Date of birth _ _ / _ _ / _ _ _ _ | 15. Sex ☐ M ☐ F | 16. Relationship code |
| 17. Address *(if different from enrollee)* | | 18. Medicare ☐ A ☐ B ☐ D | 19. TRICARE ☐ | 20. Other insurance ☐ |
| | | 21. Name of insurance | | 22. Insurance policy no. |
| Name of family member *(last, first, middle initial)* | Social Security Number | Date of birth _ _ / _ _ / _ _ _ _ | Sex ☐ M ☐ F | Relationship code |
| Address *(if different from enrollee)* | | Medicare ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐ |
| | | Name of insurance | | Insurance policy no. |
| Name of family member *(last, first, middle initial)* | Social Security Number | Date of birth _ _ / _ _ / _ _ _ _ | Sex ☐ M ☐ F | Relationship code |
| Address *(if different from enrollee)* | | Medicare ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐ |
| | | Name of Insurance | | Insurance policy no. |

| Part B - Present Plan | | Part C - New Plan | | Part D - Event Code | |
|---|---|---|---|---|---|
| 1. Plan name | 2. Enrollment code | 1. Plan name | 2. Enrollment code | 1. Event code | 2. Date of event _ _ / _ _ / _ _ _ _ |

## Part E - Election to Suspend/Cancel *(fill in this part if you wish to suspend/cancel your enrollment in the FEHBP. See page 2 of the instructions.)*

I elect to suspend or cancel my enrollment and have initialed the appropriate box below.

| | *Name* | *Social Security Number* |
|---|---|---|
| ☐ I will be covered under the FEHB enrollment of: | | |

☐ I am covered by a Medicare Advantage plan, Medicaid or a similar State-sponsored program of medical assistance for the needy. I am enclosing evidence of my coverage.

☐ I will be using CHAMPVA, TRICARE, or TRICARE for Life (enrollees over age 65 with Medicare Parts A and B). I am enclosing copies of my CHAMPVA authorization card or my Uniformed Services identification card and, if over age 65, my Medicare card showing Parts A and B.

☐ I am or will be covered by Peace Corps volunteer health benefits. I am enclosing evidence of my coverage.

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## Part F - Signature *(all who register or cancel must fill in this part)*

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| 1. Your signature *(do not print)* | 2. Telephone number | 3. Date *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _ | 4. Retirement Claim Number |
|---|---|---|---|

## Part G - To be completed by OPM

| 1. Name and address | 2. Date received in OPM _ _ / _ _ / _ _ _ _ | 3. Effective date of action _ _ / _ _ / _ _ _ _ | 4. Payroll office number |
|---|---|---|---|
| **U.S. Office of Personnel Management**<br>**Retirement Services Programs**<br>**Washington, D.C. 20415** | 5. Signature of authorized agency official | | 6. Date _ _ / _ _ / _ _ _ _ |

**Remarks** *(For use by OPM only.)*