IMPORTANT

DPRS OPEN SEASON INFORMATION

PLEASE READ ALL INFORMATION AND INSTRUCTIONS.

RETURN PAGE 2 OF THIS FORM ONLY IF YOU WISH TO MAKE A CHANGE.

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Privacy Act Statement. The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program (FEHB) under Chapter 8, 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.

Agencies other than the OPM may have further routine uses for disclosure of information for the records system in which the file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

Public Burden Statement. 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 National Finance Center, Direct Premium Unit (DPRS) Billing Unit, P.O. Box 61760, New Orleans, LA 70161, (3206-0202). The OMB number, 3206-0202 is currently valid. NFC may not collect this information, and you are not required to respond, unless this number is displayed.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

FEHB

OPEN SEASON
DPRS-2809
OMB 0505-0024
(Revised 10/14)

REQUEST TO CHANGE FEHB ENROLLMENT FOR 2015 PLAN YEAR

Read the enclosed instructions before completing this form. Return this form to:
USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161
You may fax your form to 303-274-3805.
Do not take any action to maintain your present coverage.

COMPLETE THIS FORM *ONLY* IF YOU ARE MAKING CHANGES.

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at **www.opm.gov/insure/health**.

SECTION I - Enrollee and Family Member Information *(For additional family members use a separate sheet and attach.)*

1. ENROLLEE NAME *(last, first, middle initial)*	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH *(mm/dd/yyyy)*	4. SEX ☐ M ☐ F	5. ARE YOU MARRIED? ☐ YES ☐ NO

6. HOME MAILING ADDRESS *(including ZIP Code)*	I need to correct my address. The changes are indicated in item 6 ☐	7. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D	8. MEDICARE CLAIM NUMBER

9. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 10 below. ☐ NO

10. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.*	NAME OF OTHER INSURANCE	POLICY NUMBER

Dependents' Information. Fill in the applicable information in the blocks below. For additional family members please use a separate sheet of paper. Relationship Codes are: 01. Spouse; 19. Child under age 26; 09. Adopted child; 17. Step child; 10. Eligible foster child; 99. Disabled child age 26 or older who is incapable of self-support because of a physical or mental disability that began before his/her 26th birthday.

11. NAME OF FAMILY MEMBER *(last, first, middle initial)*	12. SOCIAL SECURITY NUMBER	13. DATE OF BIRTH *(mm/dd/yyyy)*	14. SEX ☐ M ☐ F	15. RELATIONSHIP CODE

16. ADDRESS *(if different from enrollee)*	17. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D	18. MEDICARE CLAIM NUMBER

19. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 20 below. ☐ NO

20. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.*	NAME OF OTHER INSURANCE	POLICY NUMBER

21. EMAIL ADDRESS *(if home address is different from enrollee's)*	22. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)*

23. NAME OF FAMILY MEMBER *(last, first, middle initial)*	24. SOCIAL SECURITY NUMBER	25. DATE OF BIRTH *(mm/dd/yyyy)*	26. SEX ☐ M ☐ F	27. RELATIONSHIP CODE

28. ADDRESS *(if different from enrollee)*	29. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D	30. MEDICARE CLAIM NUMBER

31. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 32 below. ☐ NO

32. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.*	NAME OF OTHER INSURANCE	POLICY NUMBER

33. EMAIL ADDRESS *(if home address is different from enrollee's)*	34. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)*

SECTION II - FEHB Plan You Are Currently Enrolled In

1. PLAN NAME	2. ENROLLMENT CODE

Section III - FEHB Plan You Are Changing to

1. PLAN NAME	2. ENROLLMENT CODE

SECTION IV - Signature

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. DATE *(mm/dd/yyyy)*

3. EMAIL ADDRESS	4. PREFERRED TELEPHONE NUMBER ( )

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

FEHB

OPEN SEASON

INFORMATION AND INSTRUCTION SHEET FOR COMPLETING FORM DPRS-2809

Carefully read the following instructions before completing your request form.

You must make all changes through the National Finance Center.

The enclosed Direct Premium Remittance System (DPRS) form, DPRS-2809, should not be used by anyone other than the addressee and must be signed by the addressee.

DPRS-2809 allows you to change your current health benefits plan, if your account is current.

If you decide not to make an enrollment change this year, it is not necessary to complete the form, DPRS-2809. Please read both the form and the accompanying plan comparison charts to make sure your current health benefits plan and option of coverage, especially Health Maintenance Organization (HMO) plans, will still be available to you in 2015. If your plan is not listed, you must select another plan during this Open Season period (November 10 through December 8, 2014) to be assured of continued health benefits coverage.

Important. You should also carefully review the 2015 premium cost shown in the plan comparison charts for your plan and option of coverage. There are only limited opportunities, which permit you to change your enrollment outside of the Open Season. If you do not change your enrollment during the Open Season, you may not be eligible to change later, even if you do not wish to pay an increased premium cost for your enrollment.

Note: Procedures for Brochure Request. All brochure plan requests must be made through the carrier from whom you wish to receive the brochure. To contact the carrier for a plan brochure, call the phone number provided in this package. NFC will not stock any brochures.

Section I, Enrollee and Family Member Information. Please complete all information in blocks 1-34 for the primary enrollee and your dependents. If your address is incorrect on the enclosed form, enter the changes in Box 6 and check the box indicating a change. Mark a line through the erroneous information of your preprinted address. The address you provide here will be used by DPRS to mail all future correspondence, including health benefits information.

Section II, Enrollment Codes and Plan Names. Please complete the plan name and enrollment code for the plan you are currently enrolled in 2014.

Section III, Enrollment Codes and Plan Names. Please complete the plan name and enrollment code for the plan you choose to enroll in 2015.

Section IV, Authorization. You must sign and date the form. No changes will be made unless the enrollee signs and dates the form. Enter the daytime area code and phone number and email address where you can be contacted to answer questions concerning the information on this form.

Effective Date of Open Season Changes. All enrollment changes will be effective January 1, 2015. If your change is processed before January 1, 2015, the coupons received in January will reflect the new premium that will be due February 1. Otherwise, the new premium will be reflected in the coupons sent to you after the change is processed, retroactive to January 1, 2015.

Acknowledgment Letters. If you made a change in your enrollment coverage during the Open Season, a letter acknowledging your change will be mailed to you. Keep the acknowledgment letter to use as verification of your new enrollment coverage effective January 1, 2015.

Identification Cards. These cards are issued by the health plans, not DPRS. You should direct questions about identification (ID) cards to your plan. Cards are usually issued within 30 days from the date the plan receives notice of your enrollment change. Should you or your family require medical attention after the January 1, 2015 effective date, but before you receive your new ID card, you may use the letter we send you, acknowledging your open season change, as proof of your new coverage.

Please visit the following websites for comprehensive information on FEHB. www.opm.gov/healthcare-insurance/healthcare or www.opm.gov/healthcare-insurance/healthcare/reference-materials/ or www.opm.gov/openseason. In addition to the info contained in this guide you will find information on:

- Open Season Resources
- Comparing Plans
- FEHB Handbook
- Frequently Asked Questions
- Medicare and FEHB
- Health Care Reform/Affordable Care Act

Additional Help. If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the National Finance Center Contact Center at 800-242-9630 from 8:00 a.m. to 4:00 p.m., CST, weekdays or write to: **DPRS, P.O. Box 61760, New Orleans, LA. 70161-1760 or email to NFC.DPRS@nfc.gov or fax to 303-274-3805.** Visit our web site at www.nfc.usda.gov/dprs. You will be able to view the full RI 70-5 FEHB Guide under "FEHB Guides" as well as the DPRS-2809 Open Season change form under "DPRS Open Season Information".