changes in yellow were included with the 60-day package.

Health Benefits Election Form

Changes in green were made after review of the 60-day package.

Federal Employees Health Benefits Program

Form Approved:
OMB No. 3206-0141

Who May Use OPM Form 2809

- Annuitants retired under the Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS)
- Survivor annuitants under CSRS or FERS
- Former spouses
- Children and former spouses who are eligible for temporary continuation of coverage

Instructions for Completing OPM 2809

Type or print firmly.

Part A — Enrollee and Family Member Information.

You must complete this part.

Item 1. Enter your legal name.

Item 2. Provide your Social Security number.

Item 3. Enter your date of birth.

Item 4. Enter your sex.

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

Item 6. Enter your emailing address.

changed from 18 to 20

Item 7. If you have Medicare, check which Parts you have, including prescription drug coverage under Medicare Part D.

Item 8. If you have Medicare, enter your Medicare Claim Number. This number is on your Medicare card.

Item 9. If you are covered by other health insurance (private, state, Medicaid, Peace Corps, TRICARE, CHAMPVA, or another FEHB enrollment), either in your name or under a family member's policy, check yes and complete item 10.

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 10. Select or write the name of any other insurance that covers you.

Item 11. If applicable, provide your email address.

Item 12. Provide your day time telephone number.

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

The instructions for completing items 13 through 24 for your initial family member also apply to the information you provide for additional family members in items 25 through 48.

Item 14. Please provide Social Security numbers for your dependents, if they have one. If your dependents do not have Social Security numbers, leave blank; benefits will not be withheld. *(See Privacy Act Statement on page 4.)*

Item 15. Provide the date of birth of the family member.

Item 16. Provide sex of family member.

Item 17. Provide the code which indicates the relationship of each family member to you.

Code	Family Relationship
01	Spouse
19	Child under age 26
09	Adopted Child
17	Stepchild
10	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.

Item 18. If your family member does not live with you, enter his/her home address.

changed from 16 to 18

Item 19. If a family member has Medicare, check which Parts he/she has, including prescription drug coverage under Medicare Part D.

changed from 17 to 19

Item 20. If your family member has Medicare, enter his/her Medicare Claim Number. This Number is on his/her Medicare card.

Item 21. Indicate whether the family member has health coverage other than Medicare.

Item 22. If a family member has TRICARE (see item 9), or other group insurance (private, state, Medicaid, Peace Corps, or another FEHB enrollment), check the box. Give the name and policy number of any other insurance this family member has.

changed from 20 to 22

Items 19, 20, 21 merged to Item 20

Item 23. Enter email address, if applicable, for your spouse or adult child.

Item 24. Enter the preferred telephone number, if applicable, of your spouse or adult child.

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 children under age 26. Eligible children include your legitimate or adopted children, step children, recognized natural children, or foster children, who live with you in a regular parent-child relationship.

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 natural or adopted children under age 26 of **both you and your former or deceased spouse**.

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In some cases, a 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 disability that existed before his/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 — FEHB Plan You Are Currently Enrolled In.

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, from the front cover of the plan brochure.

Item 2. Enter the present enrollment code from your plan or ID card.

Part C — FEHB Plan You Are Enrolling In or Changing To.

Complete this part to enroll or change your enrollment in the FEHB.

Item 1. Enter the name of the plan you are enrolling in or changing to. The plan name is on the front cover of the brochure of the plan you want to be enrolled in.

Item 2. Enter the enrollment code of the plan you are enrolling in or changing to. The enrollment code is on the front cover of the brochure of the plan you want to be enrolled in, and 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 (or in some cases work) 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 That Permits You to Enroll, Change or Cancel.

Item 1. Enter the event code that permits you to enroll, change, or cancel based on a Qualifying Life Event (QLE) from 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 8 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 the FEHB regulations at 5 CFR Part 890.

The tables have been organized by enrollee category. Each category is designated by a number, which identifies 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 Qualifying Life Event (QLE); for example, the event code 2A refers to open season.

Item 2. Enter the date of the QLE 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, 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 cancel the enrollment because you become covered under FEHB as a new spouse, your eligibility for 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, 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.

General Information

Dual Enrollment

No person (enrollee or family member) is entitled to receive benefits under more than one enrollment in the Federal Employees Health Benefits (FEHB) Program. Normally, you are not eligible to enroll if you are covered as an annuitant under your own enrollment and as a family member under someone else's enrollment in the 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.

(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 FEHB enrollment for a reason other than your becoming covered under another 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.

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: 1-855-887-4957). 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
Website:	www.opm.gov/retirement-services/
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 (FEHB) 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) as amended by Executive Order 13478 (November 18, 2009), allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. In addition, a mandatory Insurer Reporting Law (Section 111 of Public Law No. 110-173) requires your health insurance carrier to report, as directed by the Secretary of the Department of Health and Human Services ("Secretary"), information that the Secretary requires for purposes of coordination of benefits between your health plan and Medicare. In order to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on your health insurance carrier to collect Medicare Claim Numbers or Social Security Numbers from you and your eligible dependents. We therefore request that you provide a Medicare Claim Number or a Social Security Number for yourself and each of your eligible dependents. 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 30 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

QLE's That Permit Enrollment or Change		***Change Permitted***			***Time Limits***
Event 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** ***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, or divorce. *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: • 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; • Surviving spouse who was covered by FEHB immediately before survivor annuity terminated because of remarriage and whose annuity is restored; • Surviving child who was covered by FEHB immediately before survivor annuity terminated because student status ended and whose survivor annuity is restored; • 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 another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; *Note: Annuitants who previously suspended FEHB to use a Medicare Advantage Plan, TRICARE, Peace Corps, or CHAMPVA, see codes 2C and 2D.* • Loss of coverage under Medicaid or similar State-sponsored program; *Note: Annuitants who previously suspended FEHB to use Medicaid or a similar State-sponsored program, see codes 2C and 2D.* • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under a non-Federal health plan.	No	Yes	Yes	From 31 days before through 60 days after loss of coverage.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Event 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 retires 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. (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** ***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.

QLE's That Permit Enrollment or Change		***Change Permitted***			***Time Limits***
Event 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 another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; *Note: Former spouses who previously suspended FEHB to use a Medicare Advantage plan, TRICARE, Peace Corps, or CHAMPVA, see codes 3D and 3E.* • Loss of coverage under Medicaid or similar State-sponsored program; *Note: Former spouses who previously suspended FEHB to use Medicaid or a similar State-sponsored program, see codes 3D and 3E.* • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • 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 (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.** ***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: • Former spouse • Child who ceases to qualify as a family member	 Yes Yes	 N/A N/A	 N/A N/A	Within 60 days after the qualifying event, or receiving notice of eligibility, whichever is later.
4B	Open Season: • Former spouse • Child who ceases to qualify as a family member	 No No	 Yes Yes	 Yes Yes	As announced by OPM.
4C	Change in family status (except former spouse); for example, marriage, birth or death of family member, adoption, 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.

QLE's That Permit Enrollment or Change		***Change Permitted***			***Time Limits***
Event 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: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment (but see event 4E); • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • 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. (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.

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 *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _
4. Sex ☐ M ☐ F
5. Are you married? ☐ Yes ☐ No
6. Mailing address *(including ZIP Code)*
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 *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 9 on page 1.*
11. Email address
12. Preferred telephone number
13. Name of family member *(last, first, middle initial)*
14. Social Security Number
15. Date of birth *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _
16. Sex ☐ M ☐ F
17. Relationship code
18. Address *(if different from enrollee)*
19. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
20. Medicare Claim Number
21. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 22 below. ☐ No
22. Indicate the type(s) of other insurance
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 9 on page 1.*
23. Email address *(if applicable, enter email address of your spouse or adult child)*
24. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*
25. Name of family member *(last, first, middle initial)*
26. Social Security Number
27. Date of birth *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _
28. Sex ☐ M ☐ F
29. Relationship code
30. Address *(if different from enrollee)*
31. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
32. Medicare Claim Number
33. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 34 below. ☐ No
34. Indicate the type(s) of other insurance
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 9 on page 1.*
35. Email address *(if applicable, enter email address of your spouse or adult child)*
36. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*
37. Name of family member *(last, first, middle initial)*
38. Social Security Number
39. Date of birth *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _
40. Sex ☐ M ☐ F
41. Relationship code
42. Address *(if different from enrollee)*
43. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
44. Medicare Claim Number
45. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 46 below. ☐ No
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48. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

Part B - D moved to next page

Part B - FEHB Plan You Are Currently Enrolled In *(if applicable)*

1. Plan name	2. Enrollment code

Part C - FEHB Plan You Are Enrolling In or Changing To

1. Plan name	2. Enrollment code

Part D - Event That Permits You To Enroll, Change, or Cancel *(see page 2)*

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.

☐ 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. Date *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _	3. Retirement Claim Number

4. Email Address	5. Preferred telephone 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 **Retirement Services** **Washington, D.C. 20415**			**24 90 0002**
	5. Signature of authorized agency official		6. Date _ _ / _ _ / _ _ _ _

Remarks *(For use by OPM only.)*

Same changes as on Part 1 - Enrollee copy

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 *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _
4. Sex ☐ M ☐ F
5. Are you married? ☐ Yes ☐ No
6. Mailing address *(including ZIP Code)*
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 *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 9 on page 1.*
11. Email address
12. Preferred telephone number
13. Name of family member *(last, first, middle initial)*
14. Social Security Number
15. Date of birth *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _
16. Sex ☐ M ☐ F
17. Relationship code
18. Address *(if different from enrollee)*
19. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
20. Medicare Claim Number
21. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 22 below. ☐ No
22. Indicate the type(s) of other insurance
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 9 on page 1.*
23. Email address *(if applicable, enter email address of your spouse or adult child)*
24. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*
25. Name of family member *(last, first, middle initial)*
26. Social Security Number
27. Date of birth *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _
28. Sex ☐ M ☐ F
29. Relationship code
30. Address *(if different from enrollee)*
31. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
32. Medicare Claim Number
33. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 34 below. ☐ No
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40. Sex ☐ M ☐ F
41. Relationship code
42. Address *(if different from enrollee)*
43. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
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48. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

Part B - FEHB Plan You Are Currently Enrolled In *(if applicable)*		Part C - FEHB Plan You Are Enrolling In or Changing To	
1. Plan name	2. Enrollment code	1. Plan name	2. Enrollment code

Part D - Event That Permits You To Enroll, Change, or Cancel *(see page 2)*	
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.

☐ 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. Date *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _	3. Retirement Claim Number
4. Email Address		5. Preferred telephone 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 **Retirement Services** **Washington, D.C. 20415**	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _	**24 90 0002**
	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 *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _
4. Sex ☐ M ☐ F
5. Are you married? ☐ Yes ☐ No
6. Mailing address *(including ZIP Code)*
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 *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 9 on page 1.*
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12. Preferred telephone number
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14. Social Security Number
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17. Relationship code
18. Address *(if different from enrollee)*
19. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
20. Medicare Claim Number
21. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 22 below. ☐ No
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Part B - FEHB Plan You Are Currently Enrolled In *(if applicable)*		Part C - FEHB Plan You Are Enrolling In or Changing To	
1. Plan name	2. Enrollment code	1. Plan name	2. Enrollment code

Part D - Event That Permits You To Enroll, Change, or Cancel *(see page 2)*	
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.

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☐ 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. Date *(mm/dd/yyyy)* _ _ / _ _ / _ _ _ _	3. Retirement Claim Number
4. Email Address		5. Preferred telephone 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 **Retirement Services** **Washington, D.C. 20415**	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _	**24 90 0002**
	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

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4. Sex ☐ M ☐ F
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6. Mailing address *(including ZIP Code)*
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8. Medicare Claim Number
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40. Sex ☐ M ☐ F
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48. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

Part B - FEHB Plan You Are Currently Enrolled In *(if applicable)*		Part C - FEHB Plan You Are Enrolling In or Changing To	
1. Plan name	2. Enrollment code	1. Plan name	2. Enrollment code

Part D - Event That Permits You To Enroll, Change, or Cancel *(see page 2)*	
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*
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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
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	5. Signature of authorized agency official		6. Date _ _ / _ _ / _ _ _ _

Remarks *(For use by OPM only.)*