# IMPORTANT

## DIRECT PREMIUM REMITTANCE SYSTEM
## DPRS OPEN SEASON INFORMATION

**Please Note:** You will receive this notification including direct links to OPM's open season materials along with the FEHB SF-2809 form on page 2. Open Season information should be reviewed online to assist you in making your open season changes.

Please visit the following web site for comprehensive information about your FEHB and Open Season at wwww.opm.gov/healthcare-insurance/healthcare. You will find information on:

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

If any additional assistance is needed in completing your form or questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, you may contact the National Finance Center, GISB Help Desk at 1-800-242-9630 from 8:00 a.m. to 4:00 p.m. CST, Monday thru Friday or you may also write to: USDA/NFC/DPRS Billing Unit, P O Box 61760, New Orleans, LA, 70161-1760 or email to NFC.DPRS@usda.gov or fax to 303-274-3805.

You may also visit our website at https://nfc.usda.gov/clientservices/insurance/services/dprs for important FEHB information.

**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, (0500-0024). The OMB number, 0500-0024 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 10/15)

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 ( ) |
|---|---|
| | |