



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.
- 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. Write the name of any other insurance that covers you. An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. If you or a family member is covered under another FEHB enrollment, check the FEHB box and Contact OPM immediately as this is a dual coverage situation. Some examples of how this could occur are:
 - You are enrolling in an FEHB Self Only plan while your spouse has either an FEHB Self Plus One or Self and Family plan, in which you are already covered.
 - You are enrolling in an FEHB Self Plus One plan while you are also covered under your spouse's FEHB Self Plus One plan or FEHB Self and Family plan.
 - You are enrolling in an FEHB Self and Family plan while your spouse is already enrolled in either an FEHB Self Only plan, an FEHB Self Plus One plan that covers you, or an FEHB Self and Family plan that covers you.

- You are an employee under age 26 and have no eligible family members. You are enrolling in your own FEHB plan while you are covered under your parent's FEHB Self Plus One plan or Self and Family plan.
- You are an annuitant who is reemployed in the Federal government. You are enrolling in an FEHB plan as an employee while you are covered under your own or a family member's FEHB plan.
- Item 11. If applicable, provide your email address.
- Item 12. Provide your day time telephone number.

If your enrollment is for Self and Family, or Self Plus One, 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.
- Item 19. If a family member has Medicare, check which Parts he/she has, including prescription drug coverage under Medicare Part D.
- 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.

- 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 Plus One enrollment include one eligible family member (spouse or child under age 26) designated by you. A Self and Family enrollment includes you and all of your eligible family members.

Eligible children include your children born within marriage or adopted children; stepchildren (may include children of your same-sex domestic partner*), 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 Plus One or Self and Family enrollment are the natural or adopted children under age 26 of *both you and your former or deceased spouse*.

In some cases, a disabled child age 26 or older is eligible for coverage under your Self Plus One or 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 (OPM) can give you additional details about family member eligibility including any certification or documentation that may be required for coverage. Contact OPM for more information about covering foster child(ren), or child(ren) of your same-sex domestic partner who you would marry but for your state's marriage law.

Survivor Benefits

For your surviving family members to continue your FEHB enrollment after your death, all of the following requirements must be met:

Self Plus One

- You must have been enrolled for Self Plus One at the time of your death; and
- Your designated family member must be entitled to an annuity as your survivor.

Note: The only survivor eligible to continue the health benefits enrollment is the designated family member covered under FEHB on the date of death as long as that individual is entitled to a survivor annuity. No other family members are entitled to continue the enrollment even though they may be entitled to a survivor annuity.

Self and Family

- You must have been enrolled for Self and Family at the time of your death; and
- At least one family member must be entitled to an annuity as your survivor.

Note: All of your survivors who meet the definition of "family member" can continue their health benefits coverage under your enrollment as long as any one of them is entitled to a survivor annuity. If the survivor annuitant is the only eligible family member, the retirement system will automatically change the enrollment to Self Only.

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 current enrollment code from your plan 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 Program.

- 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, Self Plus One, 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 Parts 890 and 892.

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

- Annuitants, including individuals receiving monthly compensation from the Office of Workers' Compensation Programs
- 3 Former spouses eligible for coverage under the Spouse Equity provisions of FEHB law.

^{*}If you would marry but you live in a state that does not allow same-sex couples to marry.

- 4 TCC enrollees.
- 5 Reemployed annuitants and Survivor Annuitants who are eligible for FEHB coverage unless you waive participation in premium conversion.

Following each number is a letter which identifies a specific Qualifying Life Event (OLE); 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:

- Enable an employee under age 26 who is covered under a parent's Self Plus One or Self and Family FEHB enrollment to enroll in FEHB to cover his or her own spouse and/or child;
- Enable an employee under age 26 who is covered under a parent's Self Plus One or Self and Family FEHB enrollment, but lives outside his or her parent's HMO service area, to have FEHB coverage;
- Enable an employee who separates or divorces to enroll in FEHB to cover family members who move outside the HMO service area of the covering FEHB Self Plus One or Self and Family enrollment.

In these unusual situations, each enrollee must notify his or her plan as to which family members are covered under which 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 Self Plus One, or 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 Self and Family to Self Plus One or Self Only or from Self Plus One 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 Plus One or Self and Family	From One Plan or Option to Another	Switch Designated Family Member	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 eligible family members are family members of the d				members can o	only occur if the additional
2A	Open Season	No	Yes	Yes	Yes	As announced by OPM.
2B	Change in family status; for example: marriage, birth or death of family member, adoption, or divorce. <i>Note:</i> Survivors cannot change plans because of the death of the annuitant. Note: Survivors cannot change plans because of the death	No	Yes	Yes	Yes	From 31 days before through 60 days after the event.
	of the annuitant.					
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	No	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	No	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	No	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 Plus One or Self Only of the covering enrollment.	Yes	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.

	QLE's That Permit Enrollment or Change		Change Per	mitted		Time Limits
Event Code	Event	From Not Enrolled to Enrolled	From Self Only to Self Plus One or Self and Family	From One Plan or Option to Another	Switch Designated Family Member	When You Must File Health Benefits Election Form With the Office of Personnel Management
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; • 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 (but see events 2C and 2D); Loss of coverage under a non-Federal health plan.	No	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
2Н	Annuitant or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	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	Yes	When you or a family member notify OPM of a change of address outside the plan's service area.
2Ј	Employee in an overseas post of duty retires or dies.	No	Yes	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	No	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	No	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	No	OPM will advise annuitant of the options.
3	Former Spouse Under The Spouse Equity Provision Note: Former spouse may change to Self Plus One the annuitant.		mily only if fa	mily mem	bers are also	eligible family members of
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	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.
3В	Open Season.	No	Yes	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	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	Yes	From 31 days before through 60 days after involuntary loss of coverage.

	QLE's That Permit Enrollment or Change		Change Per	mitted		Time Limits
Event Code	Event	From Not Enrolled to Enrolled	From Self Only to Self Plus One to Self and Family	From One Plan or Option to Another	Switch Designated Family Member	When You Must File Health Benefits Election Form With the Office of Personnel Management
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	No	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	Yes	From 31 days before through 60 days after date of loss of coverage
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	Yes	From 31 days before through 60 days after loss of coverage.
3Н	Former spouse or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	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	Yes	When you or a family member notify OPM of a change of address outside the plan's service area.
3Ј	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	No	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	No	Retirement system will advise former spouse of options.
4	Temporary Continuation of Coverage (TCC) For	Eligible Forme	er Spouses and	l Children	•	
	<i>Note:</i> Former spouse may change to Self Plus One the annuitant.	e or Self and Fa	nmily only if fa	nmily mem	bers are also	eligible family members of
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	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	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	Yes	From 31 days before through 60 days after event.

	QLE's That Permit Enrollment or Change		Change Per	mitted		Time Limits
Event Code	Event	From Not Enrolled to Enrolled	From Self Only to Self Plus One to Self and Family	From One Plan or Option to Another	Switch Designated Family Member	When You Must File Health Benefits Election Form With the Office of Personnel Management
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	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	No	From 31 days before through 60 days after the event. Enrollment is retroactive to the date of the loss of the other FEHB coverage.
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 Plus One or 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	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	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	No	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	No	At any time beginning on the 30th day before becoming eligible for Medicare.



Form Approved: OMB No. 3206-0141

Part A - Enrollee and Family Member Information (for	additional family member	re at	tach a	conar	ato chi	eat)						
1. Enrollee name (last, first, middle initial)	2. Social Security Number			_		•	4.	Sex		15	Are you r	narried?
11 Zinonee hame (vast, j.v.s.) maate minut	2. Social Security Training								_			
					<u> </u>			M	F		Yes	No
6. Mailing address (including ZIP Code)		7.	If you check a	are cov	vered by apply.	Medicare,	8.	Medica	are <mark>Clai</mark> ı	n Nur	nber	
			Α	E		D						
		9.				nsurance o	ther th	nan Me	dicare?			
			•		•				_			
			Yes, i	ndicate	e in iten	10 below.			No			
10. Indicate the type(s) of other insurance												
TRICARE Other Name of other insurance:								-	ber:			
FEHB An FEHB Self Plus One enrollment covers the enrol enrollee and all eligible family members. No person												overs the
11. Email address	may be covered talder more a							, , 01 110	> 011	pase		
11. Email address		12.	Prefeii	rea tere	phone i	lumber						
13. Name of family member (last, first, middle initial)	14. Social Security Number	15.	Date of	of birth	(mm/de	√ yyyy)	16	. Sex		17.	Relations	ship code
			/	,	/			М	F			
18. Address (if different from enrollee)		19				er is covere	d 20		licare Cl	aim N	umber	
10. Hadress (y aggerem from emonee)			by Me	dicare,	check a	ll that appl	y. 20	. 11100	iletire Ci	unin i	umoer	
			A	E		D						
		21.	Is this	family	memb	er covered	by ins	urance	other th	an M	edicare?	
			Yes. i	ndicate	e in iten	22 below.			No			
22. Indicate the type(s) of other insurance			,-									
TRICARE Other Name of other insurance:							Polic	v Num	ber:			
FEHB An FEHB Self Plus One enrollment covers the enrol		mbei	r desigr	nated b	v the en	rollee. An		-		ilv enr	ollment c	overs the
enrollee and all eligible family members. No person	may be covered under more to	han e	one FE	HB eni	ollmeni	. See instru	ections	for ite	em 9 on	page	1.	
23. Email address (if applicable, enter email address of your spot	use or adult child)	24.	Preferi	red tele	phone i	number (if a	applica	able, e	nter pre	ferrea	phone ni	ımber of
			your s	pouse (or adult	child)						
25. Name of family member (last, first, middle initial)	26. Social Security Number	27	Doto	of hieth	(mana/d	1/2000)	20	. Sex		20	Dalation	ship code
23. Name of family member (tast, just, made initial)	20. Social Security Number	21.	Date	on on un	(mm/ac	vyyy)	20.	. Sex		29.	Kelauons	sinp code
			/	/	′ — — -			M	F			
30. Address (if different from enrollee)		31.	If this	family	member	er is covere	d 32.	. Med	licare <mark>C</mark> l	aim N	umber	_
			A	E E		D	, ·					
		33.				er covered	by ins	urance	other th	an M	edicare?	
							•		_			
			Yes, i	ndicate	e in iten	34 below.			No			
34. Indicate the type(s) of other insurance												
TRICARE Other Name of other insurance:								-	ber:			
FEHB An FEHB Self Plus One enrollment covers the enro enrollee and all eligible family members. No person												overs the
												h a.r. af
35. Email address (if applicable, enter email address of your spou	se or aaun chna)	30.			ephone i or adult	number (<i>if a</i> child)	іррис	авіе, е	nier prę	jerrea	pnone ni	imber oj
37. Name of family member (last, first, middle initial)	38. Social Security Number	39.	Date of	of birth	(mm/de	l/yyyy)	40.	. Sex		41.	Relations	ship code
			/	,	/			М	F			
42. Address (if different from enrollee)		43.	If this	family	membe	r is covered	1 44.		licare Cl	aim N	umber	
42. Tudiess (y ayjerem from emonee)			y Med	licare,	check a	that apply	y.	. 11100	nearo Ci	dilli i	umoer	
			A	E	3	D						
		45.	Is this	family	memb	er covered l	by ins	urance	other th	an M	edicare?	
		\vdash	Yes i	indicate	e in iten	46 below.			No			
46. Indicate the type(s) of other insurance			1 05, 1	inarcut	o in item	i to below.			110			
TRICARE Other Name of other insurance:							Polic	v Num	ber:			
FEHB An FEHB Self Plus One enrollment covers the enro.	llee and one eligible family me	mhe	r desior	nated h	v the en	rollee An		-		lv enr	ollment c	overs the
enrollee and all eligible family members. No person												
47. Email address (if applicable, enter email address of your spou	se or adult child)	48.	Preferi	red tele	phone i	number (if a	applica	able, e	nter pre	ferrea	phone ni	ımber of
					or adult				- •			-
		i										

Part B - FEHB Plan You Are Currently Enrolled	In (if applicable)	Part C - FEHB Plan You A	re Enrolling In or Changing To
1. Plan name	2. Enrollment code	Plan name	2. Enrollment code
Part D - Event That Permits You To Enroll, Chan	ge, or Cancel (see page 2)		
1. Event code 2. Date of event			
//			
Part E - Election to Suspend/Cancel (fill in this par	t if you wish to suspend/cancel	your enrollment in the FEH	BP. See page 2 of the instructions.)
I elect to suspend or cancel my enrollment and have initialed			1
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	n of medical assistance for the neo	edy. I am enclosing evidence of my coverage.
I will be using CHAMPVA, TRICARE, or TRICARE for card or my Uniformed Services identification card and,			closing copies of my CHAMPVA authorization
I am or will be covered by Peace Corps volunteer health	h benefits. I am enclosing evidence	of my coverage.	
I am cancelling my enrollment for reasons other than the	ne three situations shown above. I u	nderstand I can never reenroll i	n the FEHBP.
Part F - Signature (all who register or cancel must)	fill in this part)		
WARNING: Any intentionally false statement on this than \$10,000 or imprisonment of not mo	11 0 1		n of the law punishable by a fine of not more
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			
Name and address	2. Date received in OPM	3. Effective date of action	4. Payroll office number
U.S. Office of Personnel Management	/ /	/ /	24 90 0002
Retirement Services	5. Signature of authorized agence	ey official	6. Date
Washington, D.C. 20415		•	/ /
Remarks (For use by OPM only.)			
Remarks (1 of use by O1 in only.)			





Part A - Enrollee and Family Member Information (for	additional family member	rs att	ach a	separ	ate she	eet)						
1. Enrollee name (last, first, middle initial)	2. Social Security Number						4	4. S	ex		5. Aı	e you married?
			/	/	/			-	М	F	\vdash	es No
6. Mailing address (including ZIP Code)		7.	If you	are cov	ered by	y Medica	ire, 8					
			check a	ll that	apply.	7						
		0	Aravo	E		D insurance	o otho	or the	n Ma	diagra?		
		۶.	Aic yo	u cove	icu by i	insuranc	e ome	51 U116	an ivic	uicare:		
			Yes, i	ndicate	in iten	n 10 belo	w.			No		
10. Indicate the type(s) of other insurance												
TRICARE Other Name of other insurance:	1 1 1 11 1 1 1					11		-	Num		, ,	
FEHB An FEHB Self Plus One enrollment covers the enrol enrollee and all eligible family members. No person												lment covers the
11. Email address	·	12.	Preferi	ed tele	phone 1	number						
13. Name of family member (<i>last, first, middle initial</i>)	14. Social Security Number	15	Date	of hirth	(mm/d	d/mm)		16	Sex		17 R	elationship code
13. Ivaine of failing member (tast, just, made mutal)	14. Social Security Humber	13.	Date (n onti	/ (mm) ac	w yyyy)		10.	БСЛ		17. 10	ciationship cod
10 111 (10 110)		-	/	<u> /</u>				20	M	F		
18. Address (if different from enrollee)		19.	by Me	family dicare,	membe check a	er is covall that a	ered pply.	20.	Med	icar <mark>e Cl</mark>	aım Nuı	nber
			A	E		D						
		21.	Is this	family	memb	er covere	ed by	insu	rance	other th	an Med	icare?
		П	Yes, i	ndicate	e in iten	n 22 belo	w.			No		
22. Indicate the type(s) of other insurance		1								-1		
TRICARE Other Name of other insurance:							P	olicy	Num	ber:		
FEHB An FEHB Self Plus One enrollment covers the enrol	lee and one eligible family me	mber	design	ated b	y the en	rollee. A	n FE	HB .	Self a	nd Fami	ly enrol	lment covers the
enrollee and all eligible family members. No person												1 1 1
23. Email address (if applicable, enter email address of your spot	ise or adult child)	24.	your sp	ed tele oouse o	phone i or adult	number (t child)	ıf app	olica	ble, e	nter prej	erred p	hone number of
25. Name of family member (last, first, middle initial)	26. Social Security Number	27.	Date of	of birth	(mm/de	d/yyyy)		28.	Sex		29. R	elationship code
		-	/	/	′ _				M	F		
30. Address (if different from enrollee)		31.	If this	family	membe	er is cov ll that ap	ered	32.	Med	icare Cl	aim Nu	nber
			A [E		D	Α-).					
		33.	Is this	family	memb	er cover	ed by	insu	rance	other th	an Med	icare?
			Vac i	ndicate	in itan	n 34 belo	NX7			No		
34. Indicate the type(s) of other insurance			1 05, 1	nuican	in nen	11 34 0010	JW.			NO		
TRICARE Other Name of other insurance:							P	olicy	Num	ber:		
FEHB An FEHB Self Plus One enrollment covers the enrol	lee and one eligible family me	mber	design	ated b	y the en	ırollee. A					ly enrol	lment covers the
enrollee and all eligible family members. No person	may be covered under more th	han o	ne FEI	НВ епі	ollmeni	t. See ins	tructi	ions	for ite	em 9 on j	page 1.	
35. Email address (if applicable, enter email address of your spou	se or adult child)				phone i		if app	olica	ble, e	nter prej	erred p	hone number of
					n aami	· cmu)						
			your s _l									
37. Name of family member (last, first, middle initial)	38. Social Security Number		, ,	of birth	(mm/de	d/yyyy)		40.	Sex		41. R	elationship code
37. Name of family member (last, first, middle initial)	38. Social Security Number		, ,	of birth	(mm/de	d/yyyy)		40.	Г	F	41. R	elationship cod
	38. Social Security Number	39.	Date of	/ family	membe	– – er is cove			M	F icare Cl		
37. Name of family member (last, first, middle initial) 42. Address (if different from enrollee)	38. Social Security Number	39.	Date of	/ family icare,	membe	 er is cove ll that ap			M			
	38. Social Security Number	39.	Date of/ If this : y Med	family icare,	membe check a	er is cove ll that ap	ply.	44.	M Med	icare <mark>Cl</mark>	aim Nui	mber
	38. Social Security Number	39.	Date of/ If this : y Med	family icare,	membe check a	 er is cove ll that ap	ply.	44.	M Med	icare <mark>Cl</mark>	aim Nui	mber
42. Address (if different from enrollee)	38. Social Security Number	39.	Date of/ If this y Med A Is this	family icare, E family	membe check a	er is cove ll that ap	oply.	44.	M Med	icare <mark>Cl</mark>	aim Nui	mber
42. Address (if different from enrollee) 46. Indicate the type(s) of other insurance	38. Social Security Number	39.	Date of/ If this y Med A Is this	family icare, E family	membe check a	er is covered by the	oply. ed by ow.	44.	M Med	other th	aim Nui	mber
42. Address (if different from enrollee) 46. Indicate the type(s) of other insurance TRICARE Other Name of other insurance:		43. 45.	Date of/ If this y Med A Is this Yes, i	/ family icare,	membe check a member member member in item	er is cover Il that ap Der cover on 46 belo	oply. ed by ow. Po	insu	M Med	other th No ber:	aim Nui	nber)
42. Address (if different from enrollee) 46. Indicate the type(s) of other insurance	lee and one eligible family me	39. 43. 45.	Date of/ If this y Med A Is this Yes, i	family icare, Family family ndicate	membe check a member member in item	er is covered by the second of	oply. ed by ow. Po	insu	M Med	other th No ber: nd Fami	aim Nui	nber)
42. Address (if different from enrollee) 46. Indicate the type(s) of other insurance TRICARE Other Name of other insurance: FEHB An FEHB Self Plus One enrollment covers the enrol	lee and one eligible family me may be covered under more ti	39. 43. 45.	Date of/ If this y Med A Is this Yes, i	family icare, Family family family ndicate acted by HB enr	membecheck a membecheck a membecheck in item membecheck in item	er is covered that ap D Per covered a 46 below Per covered a 46 belo	ed by ow. Po An FE tructi	44. insu	M Med	other th No ber: nd Fami m 9 on p	aim Nur an Med	nber)

Part B - FEH	B Plan You Are Currently Enrolled I	n (if applicable)	Part C - FEHB Plan You A	re Enrolling In or Chan	ging To
1. Plan name		2. Enrollment cod	1. Plan name		2. Enrollment code
Part D - Ever	nt That Permits You To Enroll, Chang	ve. or Cancel (see page 2)			
	2. Date of event	ge, or current (see page 2)			
	//				
Part E - Elec	tion to Suspend/Cancel (fill in this part	t if you wish to suspend/cance	your enrollment in the FEHI	BP. See page 2 of the ins	tructions.)
I elect to susper	nd or cancel my enrollment and have initialed	the appropriate box below.			
I will be co	overed under the FEHB enrollment of:	Name		Social Security Number	
I am cover	ed by a Medicare Advantage plan, Medicaid	or a similar State-sponsored progra	m of medical assistance for the nee	edy. I am enclosing evidence	of my coverage.
	sing CHAMPVA, TRICARE, or TRICARE for Uniformed Services identification card and,			closing copies of my CHAM	PVA authorization
I am or wi	ll be covered by Peace Corps volunteer health	benefits. I am enclosing evidence	of my coverage.		
I am cance	elling my enrollment for reasons other than the	e three situations shown above. I u	ınderstand I can never reenroll i	n the FEHBP.	
Part F - Sign	ature (all who register or cancel must f	ïll in this part)			
WARNING:	Any intentionally false statement on this than \$10,000 or imprisonment of not more	11 0 1		n of the law punishable by a	fine of not more
Your signatu	are (do not print)		2. Date (mm/dd/yyyy)	3. Retirement Claim Numb	er
	, ,		//		
4. Email Addre	ess			5. Preferred telephone num	ber
Part G - To b	oe Completed by OPM				
1. Name and ac	ldress	2. Date received in OPM	3. Effective date of action	4. Payroll office number	
U.S. Office	of Personnel Management	/ /	/ /	24 90 0002	
Retirement		5. Signature of authorized agen	cv official	6. Date	
Washington	n, D.C. 20415	or organized agen			/
Remarks (Fo	r use by OPM only.)			,	
,	,				



Form Approved: OMB No. 3206-0141

Tart is Limbice and Laminy Member intolliation (707	additional family member	rs atta	ch a separate	sheet)				
1. Enrollee name (last, first, middle initial)	2. Social Security Number				4. 5	Sex		5. Are you married
			/ /			М	F	Yes No
6. Mailing address (including ZIP Code)		7. If	vou are covere	ed by Medicare,				
		ch	eck all that app	oly.				
		A A		D	41-	M	1: 9	
		9. A	re you covered	by insurance otl	ner un	an Mec	ncare?	
		7	es, indicate in	item 10 below.			No	
10. Indicate the type(s) of other insurance								
TRICARE Other Name of other insurance:						y Numb		
FEHB An FEHB Self Plus One enrollment covers the enrollee and all eligible family members. No person								
11. Email address	may be covered under more in		referred telepho			jor nei	n > on p	
11. Eman address		12. 11	ererred terepri	one number				
	I				1			l.=
13. Name of family member (last, first, middle initial)	14. Social Security Number	15. D	Date of birth (m	m/dd/yyyy)	16.	Sex		17. Relationship co
		_	_//_			M	F	
18. Address (if different from enrollee)		19. If	f this family m	ember is covered eck all that apply	20.	Medi	care Cla	aim Number
				D				
				ember covered b	y insi	urance	other th	an Medicare?
		H.					1	
22. Indicate the type(s) of other insurance)	es, indicate in	item 22 below.			No	
TRICARE Other Name of other insurance:					Polic	y Numl	ar.	
FEHB An FEHB Self Plus One enrollment covers the enrol	lee and one eligible family me	mher d	lesignated by the					ly enrollment covers
enrollee and all eligible family members. No person	may be covered under more to	han one	e FEHB enroll	ment. See instruc	tions	for ite	n 9 on p	page 1.
23. Email address (if applicable, enter email address of your spot	use or adult child)	24. Pı	referred telepho	one number (if ap	pplice	able, en	ter pref	erred phone number
		ye	our spouse or a	idult child)				
25. Name of family member (last, first, middle initial)	26. Social Security Number	27. D	Date of birth (m	um/dd/vvvv)	28.	Sex		29. Relationship co
			, ,	55557		т г		1
30. Address (if different from enrollee)		21 1	_ / / _	— — — ember is covered	22	M	F	aim Number
50. Address (y atyerent from enroutee)		by	Medicare, che	ck all that apply.	32.	Medi	care Cia	iiii Nuiiiber
		A		D				
		33. Is	s this family m	ember covered b	y insi	urance	other th	an Medicare?
		7	es, indicate in	item 34 below.			No	
34. Indicate the type(s) of other insurance		1					I	
TRICARE Other Name of other insurance:					Dolio	y Numb		
FEHB An FEHB Self Plus One enrollment covers the enrol					one.	,	er:	
				 he enrollee. An F	ЕНВ	Self an	d Fami	
enrollee and all eligible family members. No person	may be covered under more to	han one	e FEHB enroll	he enrollee. An F ment. See instruc	EHB tions	Self an for ite	d Fami n 9 on p	page 1.
	may be covered under more to	han one	e FEHB enroll	he enrollee. An F ment. See instruc one number (if ap	EHB tions	Self an for ite	d Fami n 9 on p	
enrollee and all eligible family members. No person 35. Email address (if applicable, enter email address of your spou	may be covered under more to se or adult child)	36. Pr	e FEHB enroll. referred telephour spouse or c	he enrollee. An F ment. See instruc one number (if aq adult child)	EHB tions	Self an for ite	d Fami n 9 on p	oage 1. Terred phone number
enrollee and all eligible family members. No person	may be covered under more to	36. Pr	e FEHB enroll. referred telephour spouse or c	he enrollee. An F ment. See instruc one number (if aq adult child)	EHB tions	Self an for ite	d Fami n 9 on p	page 1.
enrollee and all eligible family members. No person 35. Email address (if applicable, enter email address of your spou	may be covered under more to se or adult child)	36. Pr	e FEHB enroll. referred telephour spouse or c	he enrollee. An F ment. See instruc one number (if aq adult child)	EHB tions	Self an for iter able, en	d Fami n 9 on p	oage 1. Terred phone number
enrollee and all eligible family members. No person 35. Email address (if applicable, enter email address of your spou	may be covered under more to se or adult child)	36. Pr yo 39. D 43. If	referred telephorer spouse or a contract of birth (m	the enrollee. An F ment. See instruc- tione number (if ap adult child) mm/dd/yyyy)	tions oplice 40.	Self and for items able, en Sex	d Famil n 9 on p ter pref	oage 1. Terred phone number
enrollee and all eligible family members. No person 35. Email address (if applicable, enter email address of your spou 37. Name of family member (last, first, middle initial)	may be covered under more to se or adult child)	36. Pr yo 39. D 43. If	referred telephour spouse or a Date of birth (m// this family me Medicare, che	the enrollee. An F ment. See instruc- one number (if andult child) mm/dd/yyyy) 	tions oplice 40.	Self and for items able, en Sex	d Famil n 9 on p ter pref	eage 1. Ferred phone number 41. Relationship co
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enrollee and all eligible family members. No person 35. Email address (if applicable, enter email address of your spou 37. Name of family member (last, first, middle initial)	may be covered under more to se or adult child)	36. Pr yo 39. E 43. If y 45. Is	per FEHB enroll. The seferred telephorur spouse or comments or co	the enrollee. An Firment. See instructions number (if andult child) mm/dd/yyyy) mber is covered took all that apply. Dember covered be	40.	Self an for iterable, en	d Familian 9 on poster pref	oage 1. Serred phone number 41. Relationship co
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enrollee and all eligible family members. No person 35. Email address (if applicable, enter email address of your spoul 37. Name of family member (last, first, middle initial) 42. Address (if different from enrollee) 46. Indicate the type(s) of other insurance TRICARE Other Name of other insurance:	may be covered under more to se or adult child) 38. Social Security Number	36. Pr ya 39. E 43. If y 45. Is	Pate of birth (m// this family me Medicare, che A B s this family m	the enrollee. An Filment. See instruction number (if apadult child) am/dd/yyyy) comber is covered cock all that apply. Dember covered be item 46 below.	40. 44. Police	Self and for iteration for ite	d Famin 9 on parter pref	erred phone number 41. Relationship co
enrollee and all eligible family members. No person 35. Email address (if applicable, enter email address of your spou 37. Name of family member (last, first, middle initial) 42. Address (if different from enrollee) 46. Indicate the type(s) of other insurance	may be covered under more to se or adult child) 38. Social Security Number lee and one eligible family me	36. Pr ya 39. E 43. If y 45. Is x	Pate of birth (many pour spouse or control of the birth (many pour spous	the enrollee. An F ment. See instruc- tione number (if ap- adult child) m/dd/yyyy) mu/dd/yyyy mu/du/yyyy mu/du/yyy mu/du/yyyy mu/du/	40. 44. 44. Police Police EHB	Self and for iteration for ite	d Famin 9 on parties pref	an Medicare?
enrollee and all eligible family members. No person 35. Email address (if applicable, enter email address of your spoul 37. Name of family member (last, first, middle initial) 42. Address (if different from enrollee) 46. Indicate the type(s) of other insurance TRICARE Other Name of other insurance: FEHB An FEHB Self Plus One enrollment covers the enroll	may be covered under more to se or adult child) 38. Social Security Number Number was and one eligible family me may be covered under more to the second se	36. Pr y 2 39. E 43. If y 45. Is 2 mber d dhan one 48. Pr	pate of birth (many pour spouse or control of the part of birth (many pour spouse or control of this family many pour spouse or control of this family many pour spouse or control of this family many pour spouse or control of the part	me enrollee. An Fment. See instruction number (if apadult child) m/dd/yyyy) member is covered ck all that apply. Dember covered by item 46 below. The enrollee. An Fment. See instructione number (if apadult child)	440. 444. 444. Police EEHB	Self and Sex Medianance of Self and for items of the self and self an	d Famin 9 on parties of the Classical No Seer:	an Medicare?

Part B - FEH	B Plan You Are Currently Enrolled I	n (if applicable)	Part C - FEHB Plan You A	re Enrolling In or Chan	ging To
1. Plan name		2. Enrollment cod	1. Plan name		2. Enrollment code
Part D - Ever	nt That Permits You To Enroll, Chang	ve. or Cancel (see page 2)			
	2. Date of event	ge, or current (see page 2)			
	//				
Part E - Elec	tion to Suspend/Cancel (fill in this part	t if you wish to suspend/cance	your enrollment in the FEHI	BP. See page 2 of the ins	tructions.)
I elect to susper	nd or cancel my enrollment and have initialed	the appropriate box below.			
I will be co	overed under the FEHB enrollment of:	Name		Social Security Number	
I am cover	ed by a Medicare Advantage plan, Medicaid	or a similar State-sponsored progra	m of medical assistance for the nee	edy. I am enclosing evidence	of my coverage.
	sing CHAMPVA, TRICARE, or TRICARE for Uniformed Services identification card and,			closing copies of my CHAM	PVA authorization
I am or wi	ll be covered by Peace Corps volunteer health	benefits. I am enclosing evidence	of my coverage.		
I am cance	elling my enrollment for reasons other than the	e three situations shown above. I u	ınderstand I can never reenroll i	n the FEHBP.	
Part F - Sign	ature (all who register or cancel must f	ïll in this part)			
WARNING:	Any intentionally false statement on this than \$10,000 or imprisonment of not more	11 0 1		n of the law punishable by a	fine of not more
Your signatu	are (do not print)		2. Date (mm/dd/yyyy)	3. Retirement Claim Numb	er
	, ,		//		
4. Email Addre	ess			5. Preferred telephone num	ber
Part G - To b	oe Completed by OPM				
1. Name and ac	ldress	2. Date received in OPM	3. Effective date of action	4. Payroll office number	
U.S. Office	of Personnel Management	/ /	/ /	24 90 0002	
Retirement		5. Signature of authorized agen	cv official	6. Date	
Washington	n, D.C. 20415	or organized agen			/
Remarks (Fo	r use by OPM only.)			,	
,	,				



Form Approved: OMB No. 3206-0141

Part A - Enrollee and Family Member Information (for	additional family member	re att	ach a so	arato s	hoot)					
1. Enrollee name (last, first, middle initial)	2. Social Security Number					4. 3	Sex		5. A	re you married?
	,						_	1		
- 14 W - 14 W - 47 B - 14		-		_/			M	F		Yes No
6. Mailing address (including ZIP Code)		7.	If you are check all th	covered a lat apply	by Medicare,	8.	Medica	re Clair	n Numb	oer)
		П	A	В	D					
		9.	Are you co	vered by	y insurance o	ther th	an Med	licare?		
		\vdash	37 ' 1'	,	101 1			1		
10. Indicate the type(s) of other insurance			Yes, indic	ate in ite	em 10 below.			No		
						D . 1: .	3.71			
TRICARE Other Name of other insurance: FEHB An FEHB Self Plus One enrollment covers the enrol.					- annollas An		y Numl		h, anna	Umant account the
enrollee and all eligible family members. No person										imeni covers ine
11. Email address	<u> </u>	12.	Preferred t	elephone	e number					
				г						
-										
13. Name of family member (last, first, middle initial)	14. Social Security Number	15.	Date of bi	rth (mm/	'dd/yyyy)	16.	. Sex		17. R	telationship code
		_	/	_/			M	F		
18. Address (if different from enrollee)		19.	If this fan	nily mem	ber is covere	d 20.			aim Nu	mber
		Н		_	k all that appl	y.				
		21	A Is this for	B	D nber covered l	hry ima		o thou th	on Mad	i a a ma ?
		21.	is this ran	my mem	iber covered i	by ms	urance	omer m	an Med	icare?
			Yes, indic	ate in ite	em 22 below.			No		
22. Indicate the type(s) of other insurance										
TRICARE Other Name of other insurance:					_	Polic	y Numl	er:		
FEHB An FEHB Self Plus One enrollment covers the enrol	lee and one eligible family me	ember	designate	d by the	enrollee. An	FEHB	Self an	d Fami	ly enro	llment covers the
enrollee and all eligible family members. No person										
23. Email address (if applicable, enter email address of your spou	se or adult child)		Preferred t your spou			applice	able, en	ter prej	erred p	hone number of
			your spou.	e or aan	iii Ciiiu)					
25. Name of family member (last, first, middle initial)	26. Social Security Number	27.	Date of bi	rth (mm/	/dd/yyyy)	28.	. Sex		29. R	telationship code
			/	/			T F			
20. Address (:6.1:66		21	/	_	ber is covere	4 22	M	F	NT	1
30. Address (if different from enrollee)		31.	y Medica	e, check	all that apply	y. 32.	. Mean	care CI	aim Nu	mber
			A	В	D					
		33.	Is this fan	nily mem	iber covered l	by ins	urance	other th	an Med	icare?
		Н	Ves india	rate in ite	em 34 below.			No		
34. Indicate the type(s) of other insurance		1 1	105, marc	ute III Ite	mi o i ociow.			110		
TRICARE Other Name of other insurance:						Polic	y Numl	er:		
FEHB An FEHB Self Plus One enrollment covers the enrol	lee and one eligible family me	ember	designate	d by the	– enrollee. An		-		lv enroi	llment covers the
enrollee and all eligible family members. No person										
35. Email address (if applicable, enter email address of your spou	se or adult child)					applica	able, en	ter prej	erred p	hone number of
			your spou	se or adu	ılt child)					
37. Name of family member (<i>last, first, middle initial</i>)	38. Social Security Number	. 20	Data of b	rth (mm.	(44/2222)	40	. Sex		/1 D	telationship code
37. Name of family member (tast, jirst, madic initial)	36. Social Security Number	39.	Date of bi	iui (mm/	aa/yyyy)	40.	. Sex		41. N	leiationship code
		-	<u>/-</u> -	<u>- / </u>			M	F		
42. Address (if different from enrollee)		43.			ber is covered all that apply		. Medi	care Cl	aim Nu	mber
		\Box	A	В	D	,				
		45.			nber covered l	by ins	urance	other th	an Med	icare?
						•		7		
AC T II at all a control of the cont			Yes, indic	ate in ite	em 46 below.			No		
46. Indicate the type(s) of other insurance										
TRICARE Other Name of other insurance:					-					
FEHB An FEHB Self Plus One enrollment covers the enrol enrollee and all eligible family members. No person										lment covers the
47. Email address (if applicable, enter email address of your spou.	, or covered under more in	O		ounce	Dec monu	ons	. joi ne	> 011		
	so on adult abild)	10	Drofow-1	alamb	\ numba= /:/	an-1:	abl · ·	tar	Commo 1	hono1 c
47. Eman address (ij applicable, emer eman address of your spoul	se or adult child)		Preferred t			applica	able, en	ter prej	erred p	hone number of

Part B - FEH	IB Plan You Are Currently Enrolled I	n (if applicable)	Part C - FEHB Plan You Are Enrolling In or Changing To		
1. Plan name		2. Enrollment cod	e 1. Plan name		2. Enrollment code
Part D - Ever	nt That Permits You To Enroll, Chang	ve. or Cancel (see page 2)			
	2. Date of event	se, or current (see page 2)			
	/ /				
Part E - Elec	tion to Suspend/Cancel (fill in this part	t if you wish to suspend/cance	l your enrollment in the FEH	BP. See page 2 of the ins	tructions.)
	nd or cancel my enrollment and have initialed		•	1 0 0	,
I will be co	overed under the FEHB enrollment of:	Name		Social Security Number	
I am cover	red by a Medicare Advantage plan, Medicaid	or a similar State-sponsored progra	m of medical assistance for the nec	edy. I am enclosing evidence	of my coverage.
	sing CHAMPVA, TRICARE, or TRICARE for Uniformed Services identification card and,			closing copies of my CHAM	PVA authorization
I am or wi	ll be covered by Peace Corps volunteer health	benefits. I am enclosing evidence	of my coverage.		
I am cance	elling my enrollment for reasons other than the	e three situations shown above. I u	ınderstand I can never reenroll i	n the FEHBP.	
Part F - Sign	ature (all who register or cancel must f	ïll in this part)			
WARNING:	Any intentionally false statement on this of than \$10,000 or imprisonment of not more	11 5 1		n of the law punishable by a	fine of not more
1. Your signature (do not print)			2. Date (mm/dd/yyyy)	3. Retirement Claim Number	
			/ /		
4. Email Addre	ess		,	5. Preferred telephone num	ber
Part G - To b	oe Completed by OPM				
1. Name and ac		2. Date received in OPM	3. Effective date of action	4. Payroll office number	
U.S. Office	of Personnel Management	/ /	/ /	24 90 0002	
Retirement Services Washington, D.C. 20415		5. Signature of authorized agency official		6. Date	
				/	/
Remarks (Fo	r use by OPM only.)				
110111111111111111111111111111111111111	, who by of the one, in				