

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 Beneficiary Identifier (MBI). 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 Beneficiary Identifier. 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, 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:

- 2 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.

- 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 (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:

- 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 Statement

Pursuant to 5 U.S.C. § 552a(e)(3), this Privacy Act Statement serves to inform you of why OPM is requesting the information on this form. Authority: OPM is authorized to collect the information requested on this form pursuant to Title 5, U. S. Code, Chapter 89, sections 8905 and 8905a, which, specify the opportunities and conditions under which a retiree, survivor annuitant, or former spouse of a retiree is eligible to enroll or to change enrollment in the Federal Employees Health Benefits Program (FEHBP). OPM is authorized to collect your Social Security number by Executive Order 9397 (November 22, 1943), as amended by Executive Order 13478 (November 18, 2008). Purpose: OPM is requesting this information to elect, cancel, suspend, or change health benefits enrollment during periods other than open season. OPM, Retirement Services determines whether all conditions permitting enrollment or change in enrollment are met and implements the action. Routine Uses: The information requested on this form may be shared as a "routine use" to other Federal agencies and third-parties when it is necessary to process your application. For example, OPM may share your information with other Federal, state, or local agencies and organizations in order to determine benefits under their programs, to obtain information necessary for a determination of your disability retirement benefits, or to report income for tax purposes. OPM may also share your information with law enforcement agencies if it becomes aware of a violation or potential violation of civil or criminal law. A complete list of the routine uses can be found in the OPM/CENTRAL 1 Civil Service Retirement and Insurance Records system of records notice, available at www.opm.gov/privacy. Consequences of Failure to Provide Information: Providing this information is voluntary. However, failure to provide this information may result in the noncompliance of the provisions of title 5, U.S.C, Chapter 89. Individuals who do not provide this information can also request changes via telephone or letter, as well as using OPM

Public Burden Statement

Form 2809. The information collected can only be obtained from the respondents.

The public reporting burden to complete this information collection is estimated at 30 minutes per response, including for reviewing instructions, searching data sources, gathering and maintaining the data needed, and the completing and reviewing the collected information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden to the Office of Personnel Management, RS Publications Team at RSPublicationsTeam@OPM.gov. Current information regarding this collection of information – including all background materials — can be found at https://www.reginfo.gov/public/do/PRAMain by using the search function to enter either the title of the collection or OMB Control Number 3206-0141.

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 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
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. Note: 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.
2C	of the annuitant. 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 of annuitant.		y only if family	members	are also eligib	le family members of the		
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 <i>apply</i> 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 <i>enroll</i> 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 <i>involuntarily</i> 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	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 Form	er Spouses and	l Children	•	
	Note: Former spouse may change to Self Plus One of annuitant.	r Self and Fami	ly only if family	v members	are also eligil	ole family members of the
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.

Federal Employees Health Benefits Program

Health Benefits Election Form

Part A - Enrollee and Family Member Information (for	additional family member	re at	tach a	conar	ata sha	at)						
1. Enrollee name (last, first, middle initial)	2. Social Security Number			_			4. S	lex		I 5 A	re you married	12
11 Zinonee hame (was, j.v.s., maare minar)	2. Social Security Frances											
					<u> </u>			M	F		Yes No	
6. Mailing address (including ZIP Code)		7.	If you check a	are cov	ered by	Medicare,	8. N	Aedicar	e Bene	ficiary	Identifier	
			A	В		D						
		9.				nsurance oth	her th	an Med	licare?			
			-		-				1			
10. I. F. (d. () C. d			Yes,	indicate	in item	10 below.			No			
10. Indicate the type(s) of other insurance												
TRICARE Other Name of other insurance:								Numb				_
FEHB An FEHB Self Plus One enrollment covers the enrol enrollee and all eligible family members. No person	llee and one eligible family me may be covered under more t	embe: than i	r desigi one FE	nated b HB enr	y the en ollment	rollee. An F . See instruc	EHB ctions	Self an for iten	d Fami n 9 on 1	ly enro page 1	ollment covers :	the
11. Email address					phone n			,	I			
11. Email address		12.	TICICI	icu icic	phone i	lullibei						
13. Name of family member (last, first, middle initial)	14. Social Security Number	15.	Date	of birth	(mm/do	l/yyyy)	16.	Sex		17.	Relationship co	de
			/	/	/			M	F			
18. Address (if different from enrollee)		19.	If this	family	membe	r is covered	1 20.			neficia	ry Identifier	
			by Me	dicare,	check a	ll that apply	/. - · ·				,	
			Α	В		D						
		21.	Is this	family	membe	er covered by	y inst	irance o	other th	an Me	dicare'?	
			Yes,	indicate	in item	22 below.			No			
22. Indicate the type(s) of other insurance		1										
TRICARE Other Name of other insurance:							Polic	Numb	er:			
FEHB An FEHB Self Plus One enrollment covers the enrol	llee and one eligible family me	embe	r desigi	nated b	y the en	rollee. An F	ЕНВ	Self an	d Fami	ly enro	ollment covers	the
enrollee and all eligible family members. No person	may be covered under more t	than (one FE	HB enr	ollment	See instruc	ctions	for iten	n 9 on _I	page 1		
23. Email address (if applicable, enter email address of your spot	use or adult child)	24.					pplica	ble, en	ter pref	erred	phone number	of
			your s	pouse o	or adult	chila)						
25. Name of family member (last, first, middle initial)	26. Social Security Number	27.	Date	of birth	(mm/da	1/vvvv)	28.	Sex		29.	Relationship co	de
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		2.1						M	F		***	
30. Address (if different from enrollee)		31.	by Med	family dicare,	membe check al	r is covered I that apply.	32.	Medic	care Be	neficia	ry Identifier	
			Α	В	3	D						
		33.	Is this	family	membe	er covered by	y inst	rance o	other th	an Me	dicare?	
			Vac	indicate		34 below.			No			
34. Indicate the type(s) of other insurance			i es,	marcate	in nen	1 34 below.			No			
TRICARE Other Name of other insurance:							Police	v Numb	ar.			
FEHB An FEHB Self Plus One enrollment covers the enrol	llee and one eligible family me	mho	r dosia	nated b	v the en					lv onro	Ilment covers	
enrollee and all eligible family members. No person												nic.
35. Email address (if applicable, enter email address of your spou	se or adult child)	36.	Prefer	red tele	phone n	umber (if a)	pplica	ble, en	ter pref	erred	phone number	of
			your s	pouse o	or adult	child)						
27 N (C '1 1 (1 (C' (1111 : 111)	20 G '1G ' N 1	20	D /	C1: 4	/ /1	1/ \	140	C		T41 1	D 1 4' 1'	_
37. Name of family member (<i>last, first, middle initial</i>)	38. Social Security Number	39.	Date	oi birth	(mm/ac	Vyyyy)	40.	Sex		41.	Relationship co	oae
			/	/	′ _			M	F			
42. Address (if different from enrollee)						r is covered		Medio	care Be	neficia	ry Identifier	
			•	B	cneck a	l that apply. D	•					
		45	A Is this		membe	er covered by	v insi	irance o	other th	an Me	dicare?	
			15 1111	, 1411111)	memo	r covered o	y mse			uii ivio	arcure.	
			Yes,	indicate	in item	46 below.			No			
46. Indicate the type(s) of other insurance												
TRICARE Other Name of other insurance:							-	Numb				_
FEHB An FEHB Self Plus One enrollment covers the enrol												the
enrollee and all eligible family members. No person	<u> </u>											
47. Email address (if applicable, enter email address of your spou	se or adult child)	48.			phone n or adult		pplica	ble, en	ter pref	erred	phone number	of
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Health Benefits Election Form

Part	t A - Enrollee and Family Member Information (for	additional family member	rs att	tach a	separ	ate sh	eet)							
	Enrollee name (last, first, middle initial)	2. Social Security Number			_		•	4	4. S	ex		5.	Are you m	narried?
				/		/		-	-	_	_	-		1
			-							M	F		Yes	No
6. I	Mailing address (including ZIP Code)		7.	If you	are cov	vered by	y Medica	re, 8	3. N	Лedic	are Bene	eficiar	y Identifie	r
			<u> </u>	A	E	***	D							
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			9.	Ale yo	ou cove	ieu by	msurance	ouic	21 UI	an wi	cuicare?			
				Yes. i	indicate	e in iter	n 10 belo	w.			No			
10. I	Indicate the type(s) of other insurance		<u> </u>	,										
$\overline{}$	TRICARE Other Name of other insurance:							D	alia	. Mun	har			
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11 1										,		1 - 0 -		
11. 1	Email address		12.	Preier	rea tere	pnone	number							
13.	Name of family member (last, first, middle initial)	14. Social Security Number	15.	Date of	of birth	(mm/d	ld/vvvv)		16.	Sex		17.	Relations	hip code
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18.	Address (if different from enrollee)		19.	If this	family	memb	er is cove	ered	20.	Med	licare B	enefic	iary Identi	fier
			<u> </u>	•		_	all that ap	opiy.						
			21	A	E		D				.1 .1		1: 0	
			21.	Is this	ramily	memt	er covere	ea by	ınsu	ırance	otner ti	ian M	edicare?	
			\Box	Yes. i	indicate	e in iter	n 22 belo	w			No			
22. I	Indicate the type(s) of other insurance			100,			22 0010				110			
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22														1
23.	Email address (if applicable, enter email address of your spot	se or adult child)					number (t child)	ıf app	ouca	ible, e	nter pre	jerrea	l phone nu	mber of
				<i>you.</i> 5,	ponse.	or ciciri								
25.	Name of family member (last, first, middle initial)	26. Social Security Number	27.	Date of	of birth	(mm/d	ld/vvvv)		28.	Sex		29.	Relations	hip code
25.	Name of family member (last, first, middle initial)	26. Social Security Number	27.	Date	of birth	(mm/d	ld/yyyy)		28.	Sex		29.	Relations	hip code
25.	Name of family member (last, first, middle initial)	26. Social Security Number		/	/	′ – –				M	F			•
	Name of family member (last, first, middle initial) Address (if different from enrollee)	26. Social Security Number	31.	/ If this	/	/ / memb	— — per is cove	ered		M			Relations	•
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		26. Social Security Number	31.	If this by Med	family dicare,	memb check a	er is cove	ply.	32.	Med	licare B	enefic	iary Identi	•
		26. Social Security Number	31.	If this by Med A Is this	family dicare, Family E	member and members are a members and a members are a members and a members are a members are a members are a members are a members and a members are a members are a members are a members and a members are a members are a members and a members are a members are a members are a members and a members are a members are a members are a members and a members are a members are a members are a members are a member and a members are a members are a members and a members are a members are a members and a members are a members are a members are a members and a member	er is coverall that ap	ply. ed by	32.	Med	licare B	enefic	iary Identi	•
30.	Address (if different from enrollee)	26. Social Security Number	31.	If this by Med A Is this	family dicare, Family E	member and members are a members and a members are a members and a members are a members are a members are a members are a members and a members are a members are a members are a members and a members are a members are a members and a members are a members are a members are a members and a members are a members are a members are a members and a members are a members are a members are a members are a member and a members are a members are a members and a members are a members are a members and a members are a members are a members are a members and a member	er is covered by D	ply. ed by	32.	Med	other th	enefic	iary Identi	•
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30. 34. 35. 1 37. 42. 46. 1	Address (if different from enrollee) 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 Email address (if applicable, enter email address of your spoul s	lee and one eligible family me may be covered under more to se or adult child) 38. Social Security Number The second security Number was be covered under more to the may be covered under more to the second seco	31. 33. 33. 33. 36. 36. 39. 45.	If this by Mec A Is this Yes, i r design Date o If this by Mec A Is this Yes, i This by Mec A Is this by Mec A Is this by Mec A Is this Frequency one FE	family indicate to the pouse of birth family dicare, and be family dicare, and be family dicare, and be family dicare, and be family dicare.	member of the check and the check and the check and the check are the ch	per is covered in 34 belower covered in 34 belower covered in 34 belower covered in 34 belower covered in 46 b	Power and the property of the	insuccessions and a second sec	M Mecourance V Num Self a for ita Mecourance Num Sex M Mecourance	other the No ber: No her: No her: No ber: nd Famem 9 on her predictions of the state of the stat	ily ennefic 41. iily ennefic	edicare? rollment coll. Relations iary Identified are?	fier overs the mber of hip code fier
30. 34. 35. 1 37. 42. 46. 1	Address (if different from enrollee) 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 Email address (if applicable, enter email address of your spou Name of family member (last, first, middle initial) Address (if different from enrollee) 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 to se or adult child) 38. Social Security Number The second security Number was be covered under more to the may be covered under more to the second seco	31. 33. 33. 33. 36. 36. 39. 45. 45. 45.	If this by Med A Is this Yes, i Preferryour s Date of A Is this Yes, i This by Med A Is this Yes, i This by Med A Is this Yes, i	family licare, and telepouse of birth licare, and telepouse of	member in iter y the encorporate in iter and member in iter y the encorporate in iter y the encorporate in iter y member in iter y the encorporate in iter y the encorporate in iter y the encorporate in iter	per is covered and that ap Description of the covered and that ap Description of the covered and the covered a	Power and the property of the	insuccessions and a second sec	M Mecourance y Num Self a for ita Mecourance Num Sex M Mecourance	other the No ber: No her: No her: No ber: nd Famem 9 on her predictions of the state of the stat	ily ennefic 41. iily ennefic	edicare? rollment col. Relations iary Identifications collections collections collections	fier overs the mber of hip code fier
30. 34. 35. 1 37. 42. 46. 1	Address (if different from enrollee) 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 Email address (if applicable, enter email address of your spoul s	lee and one eligible family me may be covered under more to se or adult child) 38. Social Security Number The second security Number was be covered under more to the may be covered under more to the second seco	31. 33. 33. 33. 36. 36. 39. 45. 45. 45.	If this by Med A Is this Yes, i Preferryour s Date of A Is this Yes, i This by Med A Is this Yes, i This by Med A Is this Yes, i	family licare, and telepouse of birth licare, and telepouse of	member in iter y the encorporate in iter and member in iter y the encorporate in iter y the encorporate in iter y member in iter y the encorporate in iter y the encorporate in iter y the encorporate in iter	per is covered in 34 belower covered in 34 belower covered in 34 belower covered in 34 belower covered in 46 b	Power and the property of the	insuccessions and a second sec	M Mecourance y Num Self a for ita Mecourance Num Sex M Mecourance	other the No ber: No her: No her: No ber: nd Famem 9 on her predictions of the state of the stat	ily ennefic 41. iily ennefic	edicare? rollment coll. Relations iary Identified are?	fier overs the mber of hip code fier



Health Benefits Election Form

Part A - Enrollee and Family Member Information (for	additional family member	re at	ttach o	conar	ata sha	eat)						
1. Enrollee name (last, first, middle initial)	2. Social Security Number						4. S	lev		15	Are you mar	ried?
11 Zinonee hame (was, j.v.s., maare minar)	2. Social Security Frances								=			
					<u> </u>			M	F			No
6. Mailing address (including ZIP Code)		7.	If you check	are co	vered by	Medicare,	8. N	Medica	re Bene	ficiary	Identifier	
			A	E E		D						
		9				nsurance oth	ner th	an Med	licare?			
			Yes,	indicate	e in item	10 below.			No			
10. Indicate the type(s) of other insurance												
TRICARE Other Name of other insurance:						Ì	Polic	y Numb	er:			
FEHB An FEHB Self Plus One enrollment covers the enrol enrollee and all eligible family members. No person												rs the
	may be covered under more i						iions	jor ner	n > on p	nige 1	•	
11. Email address		12.	Preter	rea tele	ephone r	number						
13. Name of family member (last, first, middle initial)	14. Social Security Number	15.	Date	of birth	(mm/do	<i>l</i> /yyyy)	16.	Sex		17.	Relationship	code
			/	,	/			M	F			
18. Address (if different from enrollee)		19	If this	family		er is covered	20			nefici	ary Identifie	
16. Padress (y ayjerem from emonee)		17.	by Me	dicare,	check a	ll that apply	. 20.	Wicar	care De	nenen	ary racintric	
			A	F		D						
		21.	Is this	s family	y membe	er covered by	y inst	irance o	other th	an Me	dicare?	
			Yes	indicate	e in item	22 below.			No			
22. Indicate the type(s) of other insurance		1	105,	marcan	o in item	1 22 0010 W.			110			
TRICARE Other Name of other insurance:						i	Polic	y Numb	er.			
FEHB An FEHB Self Plus One enrollment covers the enrol		mhe	r desig	nated h	v the en					lv enre	ollment cove	rs the
enrollee and all eligible family members. No person	may be covered under more t	than	one FE	HB en	rollment	. See instruc	tions	for iter	n 9 on _I	page 1		75 7776
23. Email address (if applicable, enter email address of your spot	use or adult child)	24.	Prefer	red tele	phone r	number (if ap	pplica	ıble, en	ter prej	erred	phone numb	er of
			your s	pouse	or adult	child)						
25. Name of family member (last, first, middle initial)	26. Social Security Number	. 27	Doto	of binth	(/1	14	20	Sex		20	Relationship	- aada
23. Name of family member (tast, jurst, madde initial)	20. Social Security Number	27.	Date	or on u	i (mm/ac	uyyyy)	20.	Sex		29.	Kelationsiij	Code
			/	/	′ <i>– – -</i>			M	F			
30. Address (if different from enrollee)		31.	If this	family	membe	er is covered Il that apply.	32.	Medi	care Be	nefici	ary Identifie	r
			A	E E		D						
		33.				er covered by	y inst	irance o	other th	an Me	dicare?	
			ī						7			
			Yes,	indicate	e in item	34 below.			No			
34. 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												rs the
35. Email address (if applicable, enter email address of your spou						number (if ap			•			an of
55. Email address (if applicable, enter email dataress of your spou	se or admi chia)	30.			or adult		эриси	ине, еп	ier prej	erreu	рпоне пини	er oj
37. Name of family member (last, first, middle initial)	38. Social Security Number	39.	Date	of birth	(mm/da	<i>l</i> /yyyy)	40.	Sex		41.	Relationship	code
			/	/	/			М	F			
42. Address (if different from enrollee)		43.	If this	family	membe	r is covered	44.			nefici	ary Identifie	r
,			by Me	dicare,	check a	ll that apply.					,	
		Ļ	A	В		D						
		45.	Is this	s family	membe	er covered by	y inst	irance (other th	an Me	dicare?	
			Yes,	indicate	e in item	46 below.			No			
46. Indicate the type(s) of other insurance			·						1			
TRICARE Other Name of other insurance:						i	Polic	y Numb	er:			
FEHB An FEHB Self Plus One enrollment covers the enrol	llee and one eligible family me	embe	r desig	nated b	y the en					ly enre	ollment cove	rs the
enrollee and all eligible family members. No person	may be covered under more t	than	one FE	HB eni	rollment	. See instruc	ctions	for iter	n 9 on _I	page 1		
47. Email address (if applicable, enter email address of your spou	se or adult child)	48.				number (if ap	plica	ıble, en	ter prej	erred	phone numb	er of
			your s	pouse	or adult	child)						
		1										



Health Benefits Election Form

Part A - Enrollee and Family Member Information (for	additional family member	rs at	tach a	separ	ate she	et)					
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 you	are cov	ered by	Medicare,				ficiar	
			check a	ll that a	apply.	T					,
		0	A ma via	В		D nsurance oth	a a e th	on Mad	Lange		
		9.	Are yo	u cove	red by I	iisurance ou	ner un	an Mec	ncare?		
			Yes, i	ndicate	in item	10 below.			No		
10. Indicate the type(s) of other insurance											
TRICARE Other Name of other insurance:								y Numl			
FEHB An FEHB Self Plus One enrollment covers the enroll enrollee and all eligible family members. No person											
11. Email address			Preferr							0-	
11. Email address		12.	1101011	ed tere	priorie i	amoer					
12. N	14 0 110 1 1	1.5	ъ.	611.1	/ /1	*/	1.0			1.7	D 1 .: 1: 1
13. Name of family member (last, first, middle initial)	14. Social Security Number	15.	Date o	or birth	(mm/ac	Vyyyy)	16.	Sex		1/.	Relationship code
			/	/				M	F		
18. Address (if different from enrollee)		19.	If this	family dicare.	membe	r is covered ll that apply	20.	Medi	care Be	nefic	ary Identifier
			A	В		D					
		21.	Is this	family	membe	er covered by	y inst	irance	other th	an M	edicare?
		Н	Voc.	ndianta	in itam	22 below.			No		
22. Indicate the type(s) of other insurance			1 08, 1	iluicate	III Iteli	1 ZZ Delow.			NO		
TRICARE Other Name of other insurance:						i	Polic	y Numl	er:		
FEHB An FEHB Self Plus One enrollment covers the enroll	lee and one eligible family me	mbe	r design	ated b	y the en					ly enr	collment covers the
enrollee and all eligible family members. No person	may be covered under more to	han (one FE	HB enr	ollment	See instruc	ctions	for ite	n 9 on _I	page	1.
23. Email address (if applicable, enter email address of your spou	se or adult child)	24.	Preferr	ed tele	phone n or adult	umber (if ap	pplice	able, en	ter pref	errea	phone number of
			your sp	ouse o	т ааші	cnia)					
25. Name of family member (last, first, middle initial)	26. Social Security Number	27.	Date o	f birth	(mm/da	l/yyyy)	28.	Sex		29.	Relationship code
			/	/				M	F		
30. Address (if different from enrollee)		31.	If this	family	membe	r is covered	32.			nefic	ary Identifier
,		L.	Ī			l that apply.	•				•
		33	A Is this	B		D er covered b	v inci	iranca	other th	an Ma	adicara?
		33.	18 11118	raininy	шешье	or covered by	y mst	irance (-	an ivi	edicare:
			Yes, i	ndicate	in item	34 below.			No		
34. Indicate the type(s) of other insurance											
TRICARE Other Name of other insurance:								y Numl			
FEHB An FEHB Self Plus One enrollment covers the enroll enrollee and all eligible family members. No person											
35. Email address (if applicable, enter email address of your spous	se or adult child)	36.	Preferr	ed tele	phone n	umber (if aı	pplice	able, en	ter pret	errea	phone number of
	,		your sp	ouse d	r adult	child)	•				
37. Name of family member (<i>last, first, middle initial</i>)	38. Social Security Number	30	Date	f birth	(mm/d	I/2000)	40	Sex		41	Relationship code
57. Name of family member (ust, jirst, made mutal)	36. Social Security Number	39.	Date (/ OII UI	(mm/ac	v yyyy)	40.	JCX_		41.	Relationship code
			/	/				M	F		_
42. Address (if different from enrollee)						r is covered I that apply.		Medi	care Be	nefic	iary Identifier
			A	В		D					
		45.	Is this	family	membe	er covered by	y inst	irance	other th	an M	edicare?
		Н	Yes. i	ndicate	in item	46 below.			No		
46. Indicate the type(s) of other insurance			1 00, 1		-1. 1011				110		_
TRICARE Other Name of other insurance:						i	Polic	y Numl	er:		
FEHB An FEHB Self Plus One enrollment covers the enroll						rollee. An F	ЕНВ	Self an	d Fami		
enrollee and all eligible family members. No person											
47. Email address (if applicable, enter email address of your spous	se or adult child)	48.			phone n		pplice	ıble, en	ter pref	errea	phone number of
			your sp	ouse 0	. aanii	cina)					

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 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	nderstand 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
C			//		
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	cy official	6. Date	
Washington	n, D.C. 20415	- · · · · · · · · · · · · · · · · · · ·	-,	/	/
Remarks (Fo	r use by OPM only.)			,	
,	, , , , , , , , , , , , , , , , , , ,				

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 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	nderstand 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
C			//		
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	cy official	6. Date	
Washington	n, D.C. 20415	- · · · · · · · · · · · · · · · · · · ·	-,	/	/
Remarks (Fo	r use by OPM only.)			,	
,	, , , , , , , , , , , , , , , , , , ,				

Part B - FEHB Plan You Are Currently Enrolled In 1. Plan name	(if applicable) 2. Enrollment code		re Enrolling In or Changing To 2. Enrollment code	
Part D - Event That Permits You To Enroll, Change 1. Event code 2. Date of event				
Part E - Election to Suspend/Cancel (fill in this part		your enrollment in the FEHI	BP. See page 2 of the instructions.)	
I elect to suspend or cancel my enrollment and have initialed the I will be covered under the FEHB enrollment of:	he appropriate box below. <i>ume</i>		Social Security Number	
I am covered by a Medicare Advantage plan, Medicaid or	r a similar State-sponsored program	n of medical assistance for the nee	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, if	Life (enrollees over age 65 with 1	Medicare Parts A and B). I am end		
I am or will be covered by Peace Corps volunteer health by I am cancelling my enrollment for reasons other than the			n the FFHRP	
Part F - Signature (all who register or cancel must fil		nuerstanu i can never reemon n	i die Pelibi .	
	oplication or willful misrepresent		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 U.S. Office of Personnel Management	2. Date received in OPM	3. Effective date of action	4. Payroll office number	
Retirement Services	'		_ 24 90 0002	
Washington, D.C. 20415	5. Signature of authorized agency official		6. Date	
Remarks (For use by OPM only.)				

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 cod	e 1. Plan name		2. Enrollment code	
Part D - Ever	nt That Permits You To Enroll, Chang	ge, or Cancel (see nage 2)				
	2. Date of event	50, 01 Cultor (500 pugo 2)				
Part E - Elec	tion to Suspend/Cancel (fill in this para	t if you wish to suspend/cance	l your enrollment in the FEH	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	red by a Medicare Advantage plan, Medicaid	or a similar State-sponsored progra	um of medical assistance for the ne	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	e 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	ill in this part)				
WARNING:	Any intentionally false statement on this than \$10,000 or imprisonment of not more	3 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	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 agency official		6. Date		
Washington, D.C. 20415		gan, a gan, a san			/	
Remarks (Fo	r use by OPM only.)					
110111111111111111111111111111111111111	, who by of the billy.					