



Uses for the Health Benefits Election Form

The Standard Form (SF) 2809 is used for the following enrollment elections:

- Enroll or reenroll
- Elect not to enroll (eligible employees only)
- Change your enrollment or change your covered family member
- Cancel your enrollment
- Suspend your enrollment (only annuitants or former spouses covered under Spouse Equity provisions)

Note: Employees automatically participate in premium conversion unless they waive it. Refer to the [Table of Permissible Changes](#) and [Premium Conversion](#) on OPM's website.

Who May Use the SF 2809

You may use this form if you are:

- An eligible current employee
- An eligible annuitant in a retirement system other than the Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS)
- An eligible individual receiving monthly compensation from the Office of Workers' Compensation Programs (OWCP)
- A former spouse covered under the Spouse Equity law or similar statutes
- An individual eligible for Temporary Continuation of Coverage (TCC)

Note: If you are a CSRS or FERS annuitant use form [OPM 2809](#) or call the Retirement Information Office toll-free at 1-888-767-6738 for assistance.

What Is Needed to Complete the Form

- You will need approximately 30 minutes to complete this form, including reading the instructions
- Enrollment code which you can find on the cover page of the [plan brochure](#)
- Eligible family member's Social Security Number and date of birth and [eligibility documentation](#)
- Active Medicare number (if applicable)
- Policy number of other health insurance if coverage will continue after this election (if applicable)



Federal Employees Health Benefits Program Election Form

SF-2809

Use this form to enroll, elect not to enroll, change, suspend or cancel your health insurance coverage in the Federal Employees Health Benefits (FEHB) Program which includes FEHB and Postal Service Health Benefits (PSHB) plans. Read the instructions carefully to understand your election and to find the codes referenced in this form.

Part A: Information About You

1. Name: _____
(Last, First, Middle initial)

2. Home Address: _____
Street / P.O. Box City, State Zip Code

3. Email Address: _____ 4. Daytime Phone Number: _____

5. Date of Birth: _____ 6. Social Security Number: _____ 7. Sex: _____
(MM/DD/YYYY) (XXX-XX-XXXX)

8. Are you currently married? Yes No 9. Enrollee Category: _____

10. Do you have any additional health insurance coverage?

- Medicare, Medicare Number: _____ (USPS Annuitants Only) Are you claiming an exception to the Medicare Part B enrollment requirement? _____
- TRICARE
- Other, Name of Other Health Insurance: _____ Policy Number: _____

! Generally, no one can be covered under two FEHB Program plans at the same time. If you are currently covered as a family member under another FEHB or PSHB plan, see the instructions for more information.

Part B: Your Enrollment Election

1. Select one from the choices below. Use the plan brochure to find the enrollment code.

- Enroll Enrollment Code: _____
- Change Your Enrollment Current Enrollment Code: _____ New Enrollment Code: _____
- Change Family Member on Your Current Self Plus One Plan Current Enrollment Code: _____
- Add a Family Member to Your Current Self and Family Plan Current Enrollment Code: _____
- Remove an Ineligible Family Member
- Elect Not to Enroll (Employees Only)*
- Suspend Your Enrollment (Annuitants and Former Spouses Only)*
- Cancel Your Enrollment*

*This option may impact your ability to re-enroll or your eligibility for coverage in retirement. Please see the instructions.

2. What event permits you to enroll, change, or cancel your enrollment? See instructions.

Initial Opportunity to Enroll Date of Event: _____

Qualifying Life Event

Event Code: _____

Date of Event: _____
(MM/DD/YYYY)
(MM/DD/YYYY)

Open Season

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Part C: Your Family Members

List all eligible family member(s) you want covered by your enrollment. Please duplicate this page as needed for any additional family members. Your family member's enrollment is not complete without the required eligibility documents. See [FEHBP Family Member Eligibility Documents](#) for information on required documents. **You must submit a new SF 2809 to remove any family member who becomes ineligible.**

Family Member's Name: _____
(Last, First, Middle Initial)

a. Relationship: _____

b. Date of Birth: _____ c. Social Security Number: _____ d. Sex: _____
(MM/DD/YYYY) (XXX-XX-XXXX)

e. Your family member's contact information, if different from yours:

Home Address: _____
Street / P.O. Box City, State Zip Code

Email Address: _____ Phone Number: _____

f. Does your family member have any additional health insurance coverage?

Medicare, Medicare Number: _____ (USPS Annuitants Only) Is your family member claiming an exception to the Medicare Part B enrollment requirement? _____

TRICARE

Other, Name of Other Health Insurance: _____ Policy Number: _____

! Generally, no one can be covered under two FEHB Program plans at the same time. If you are currently covered as a family member under another FEHB or PSHB plan, see the instructions for more information.

Additional Family Member

Family Member's Name: _____
(Last, First, Middle Initial)

a. Relationship: _____

b. Date of Birth: _____ c. Social Security Number: _____ d. Sex: _____
(MM/DD/YYYY) (XXX-XX-XXXX)

e. Your family member's contact information, if different from yours:

Home Address: _____
Street / P.O. Box City, State Zip Code

Email Address: _____ Phone Number: _____

f. Does your family member have any additional health insurance coverage?

Medicare, Medicare Number: _____ (USPS Annuitants Only) Is your family member claiming an exception to the Medicare Part B enrollment requirement? _____

TRICARE

Other, Name of Other Health Insurance: _____ Policy Number: _____

! Generally, no one can be covered under two FEHB Program plans at the same time. If you are currently covered as a family member

under another FEHB or PSHB plan, see the instructions for more information.

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Part D: Your Signature

Warning: Any intentionally false statement on this form, supporting documentation for family member eligibility, or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

Your Signature _____

Date (MM/DD/YYYY) _____

Part E: Your Agency or Retirement System Use Only

1. Date Received: _____ 2. Effective Date: _____
(MM/DD/YYYY) (MM/DD/YYYY)

3. Name and Address of Agency or Retirement System: _____

Street Address

City, State

Zip Code

5. Payroll Office Number: _____ 4. Payroll Office Contact: _____

6. Payroll Email Address: _____ 7. Payroll Phone Number: _____

8. Name of Authorizing Official: (Print or Type)

9. Authorizing Official Phone Number: _____ 10. Authorizing Official Email Address: _____

11. I certify that, to the best of my knowledge, this enrollee and any family member(s) listed meet all eligibility requirements, and if the employee presented document(s), the document(s) I examined appear to be genuine and to relate to the appropriate individual(s).

Signature of Authorizing Official

Date (MM/DD/YYYY)

Remarks:

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Instructions for Completing SF 2809

Type or print your responses in each part of the form. Instructions are not provided for items that have an explanation on the form.

Part A – Information About You

You must complete this section with information about yourself as the Enrollee

Item	Details
7	Sex dropdown menu choices: Male, Female, or Prefer not to answer
9	Enrollee category dropdown menu choices: Employee, Annuitant, Compensation (OWCP), Former spouse (Spouse Equity), Temporary Continuation of Coverage (TCC) enrollee, Survivor annuitant, Survivor compensation
10	<p>If you have Medicare, your Medicare number can be found on the front of your Medicare card.</p> <p>United States Postal Service (USPS) annuitants only: If you are a USPS employee who is retiring at the end of the year and you are using this form to make an open season election, it will take effect when you are an annuitant (provided you are eligible to continue coverage into retirement). Therefore, if you are claiming an exception from the requirement to enroll in Medicare Part B, or providing information that you are not subject to the Medicare Part B requirement, select the option you are claiming from this dropdown menu: USPS Medicare covered annuitant who is not enrolled in Medicare Part B on or before January 1, 2025; USPS employee who is at least 64 years of age or older on or before January 1, 2025; Eligible for Veterans Affairs (VA) health care benefits; Eligible for health services from the Indian Health Service (IHS); or reside abroad. USPS employees can also report eligibility to enroll in Medicare Part A entitled under Section 1818 or 1818A. Medicare Part A enrollment under Section 1818 or 1818A applies to individuals who (1) pay the full premium for Part A because they are not insured for Medicare Part A and are over age 65 or (2) pay the full premium for Part A because they are no longer entitled to social security disability benefits but chose to continue Medicare coverage beyond the disability termination date. *Individuals eligible to enroll in Medicare Part A under section 1818 or section 1818A are not subject to the Medicare Part B requirement. Note that some of these exceptions are temporary. Keep in mind that opportunities to enroll in Medicare Part B are limited and may be subject to late enrollment penalties. For more information on exceptions to the Medicare Part B requirement, visit OPM's Postal Service Health Benefits website.</p> <p>Contact the Social Security Administration (SSA) for more information about Medicare coverage and enrollment. Visit SSA online at www.ssa.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).</p> <p>With few exceptions, it is illegal to be covered under two FEHB Program plans at the same time. You can tell if you are covered under your family member's FEHB or PSHB plan if (1) you are listed on their Self Plus One enrollment or (2) you are their spouse or child under age 26 (including an adopted child, a recognized natural child, a stepchild, or a foster child) and they are enrolled in Self and Family.</p> <p>If you are covered on someone else's FEHB or PSHB plan do not submit this enrollment form unless you want your own enrollment instead. Be aware that your other coverage will not automatically stop because you are enrolling now. Your family member must take action to remove you from their FEHB or PSHB plan. Contact your Employing Office and notify them of your situation so they can help ensure</p>

that you do not experience dual coverage.

If you are a USPS employee and are covered as a family member on someone else's FEHB plan, you may remain under that plan as long as you are an eligible family member. If you decide you want your own enrollment instead, then you must ensure your other coverage ends and you may only enroll in a PSHB plan.

Part B – Your Enrollment Election

Item	Details
1.	<p>Plan information, including links to the plan brochures, can be found on OPM's Plan Information website. Enrollment codes are listed on the cover page of the brochure. Some plans are limited to specific groups or geographic areas; you may not enroll in one of these plans unless you meet the criteria specified in the plan brochure.</p> <p>If you are electing not to enroll, or to cancel or suspend your enrollment, read the information on OPM's Termination, Conversion and Temporary Continuation of Coverage website about the possible consequences of this kind of election and make sure you understand them. Contact your employing office if you have any questions because your election may affect your eligibility to reenroll or to continue coverage into retirement.</p>
2.	<p>Select the event that lets you enroll, change, or cancel your enrollment. If you have a Qualifying Life Event (QLE), look in the QLE tables on page 9 or in the Table of Permissible Changes posted on OPM's website to find your event code. The event date is the date of your QLE (for example, the date you were married or your child's birthdate). There are time limits for making a change and the enrollment change must be because of and consistent with your QLE. Refer to the Table of Permissible Changes for more information. Depending upon the QLE, you may be required to provide supporting documentation.</p>

Part C – Your Family Members

Only eligible family members may be covered under your enrollment and their enrollment is not complete without the required eligibility documents (See Table 6 on page 12 for the list of acceptable documents). You must take timely action to remove any family member from your FEHB or PSHB plan if they become ineligible. You may use this form to remove them.

Family Members Eligible for Coverage Your current spouse

- You must be legally married.
- A common law spouse is eligible only if the marriage was initiated in a state, the District of Columbia, or other jurisdiction that recognizes such marriages.

Note: If you divorce or dissolve your marriage, your spouse is no longer an eligible family member regardless of any agreement or obligation in your divorce decree to continue to provide health insurance coverage, and you **must** take action to remove them from your plan. You may use this form to remove them.

Your child under age 26

- Biological child
- Stepchild
- Adopted child: A child is considered adopted when the child is placed for adoption with you. In other words, you have assumed legal responsibility for total or partial support of the child in anticipation of adoption.
- Foster child
 - o The child must currently live with you;

- o The parent-child relationship must be with you, not the child's biological parent;
- o You must currently be the primary source of financial support for the child; and
- o You must expect to raise the child to adulthood

Your disabled child over age 26

- Your child must be incapable of self-support because of a mental or physical disability that existed before age 26. Your child’s disability must be expected to continue for at least a year.

Item	Details
a.	Relationship dropdown menu choices: 01 - Current Spouse 19 - Child under age 26 09 - Adopted Child under age 26 17 - Stepchild under age 26 10 - Foster Child under age 26 99 - Disabled Child age 26 or older who is incapable of self-support
d.	Sex dropdown menu choices: Male, Female, or Prefer not to answer
f.	<p>United States Postal Service (USPS) annuitants only – If your Medicare covered family member is claiming an exception from the requirement to enroll in Medicare Part B, select the reason that applies to them. For more information, visit OPM's Postal Service Health Benefits website. Dropdown menu choices for claiming an exception: USPS Medicare covered annuitant who is not enrolled in Medicare Part B on or before January 1, 2025; USPS employee who is at least 64 years of age or older on or before January 1, 2025; Eligible for Veterans Affairs (VA) health care benefits; Eligible for health services from Indian Health Service (IHS); or reside abroad. USPS employees can also report family members with eligibility to enroll in Medicare Part A under Section 1818 or 1818A. Medicare Part A enrollment under Section 1818 or 1818A applies to individuals who (1) pay the full premium for Part A because they are not insured for Medicare Part A and are over age 65 or (2) pay the full premium for Part A because they are no longer entitled to Social Security disability benefits but chose to continue Medicare coverage beyond the disability termination date.</p> <p>*Individuals eligible to enroll in Medicare Part A under section 1818 or section 1818A are not subject to the Medicare Part B requirement.</p> <p>With few exceptions, it is illegal to be covered under two FEHB Program plans at the same time. If a family member you listed on this form has FEHB Program coverage under another FEHB or PSHB plan, you either need to remove them from this form or they must take action to end that other coverage. Their other coverage will not automatically stop just because you are adding them to your plan now. If you have any questions or need assistance, contact your Employing Office.</p> <p>If you are a USPS employee, please be aware that any Medicare eligible family member on your plan will also be subject to any applicable PSHB rules for Medicare Part B coverage once you become an annuitant. For more information, visit OPM's Postal Service Health Benefits website or contact your Employing Office.</p>

Part D Your Signature

Item	Details
1.	Your signature in Part D authorizes deductions from your salary, annuity, or compensation to cover your premium costs (unless you are required to make direct payments). Your signature in Part D certifies that:

- You have read and understand the definitions of eligible family members under the FEHB Program, that the family members listed in Part C meet those definitions and that the supporting evidence you have provided of their eligibility is valid.
- You understand that you must take action to remove any family member covered under your enrollment if they become ineligible.
- If you are electing not to enroll, or to cancel or suspend your enrollment, you have read the applicable eligibility information and understand the possible consequences of this election.

Your agency, retirement system, or office maintaining your enrollment cannot process your request unless you complete this part. If you are registering for someone else under a written authorization from them, sign your name in Part D and attach the written authorization. If you are registering for a former spouse eligible for coverage under the Spouse Equity provisions or for an individual eligible for TCC as their court-appointed guardian, sign your name in Part D and attach evidence of your court-appointed guardianship.

Distribution of SF 2809

Employing offices must distribute one copy of the processed SF 2809 to each of the following, as appropriate:

- Official Personnel Folder
- Gaining carrier, Losing carrier, Payroll office
- Enrollee

Additional Information

Effective Date

Except for open season, most enrollments and changes of enrollment are effective on the first day of the pay period after the office maintaining your enrollment receives this form and that follows a pay period during any part of which you are in pay status. Your employing office can give you the specific date on which your election will take effect. You are responsible for coordinating the effective date of your election with your employing office to avoid a gap in coverage.

Privacy Act and Public Burden Statements

Privacy Act Statement

Pursuant to 5 U.S.C. § 552a (e)(3), this Privacy Act Statement explains 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.C. Chapter 89 and Title 5 of the Code of Federal Regulations, Part 890 pertaining to enrollment in the Federal Employees Health Benefits (FEHB) Program or the Postal Service Health Benefits (PSHB) Program. OPM is authorized to collect your Social Security Number (SSN) by Executive Order 9397 (November 22, 1943), as amended by Executive Order 13478 (November 18, 2008), and section 6055 of the Internal Revenue Code (reporting requirements for minimum essential coverage). OPM is also authorized to collect both your Social Security Number and Medicare Number pursuant to the Mandatory Insurer Reporting Law (section 111 of Public Law 110-173). **Purpose:** The principal use of this information will be to share it with the health insurance carrier you select so that it may (1) record your enrollment in the plan, (2) verify your or your family's eligibility for payment of claims for health benefits; and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. **Routine Uses:** The information you provide on this form may also be disclosed externally with other Federal agencies or Congressional offices which may have a need to know it in connection with an inquiry or a determination of eligibility for your health benefits. 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. A list of routine uses associated with this form can be found in the Privacy Act System of Records Notice (SORN), OPM/Central-23, FEHB Program Enrollment Records, available at www.opm.gov/privacy. **Consequences of Failure to Provide Information:** Providing this information is voluntary, however failure to provide it may result in a delay in processing your enrollment. We request that you provide your and your family member's Social Security Number so that it may be used as an individual identifier in the FEHB or PSHB Program, and for other purposes. Your health insurance carrier also needs to report your Social Security Number or your Medicare Number in order to properly coordinate benefits between your health plan and Medicare. Failure to furnish your Social Security Number or Medicare Number may result in OPM's inability to ensure the prompt payment of your or your family's claims for health benefits, the proper coordination with Medicare, and the proper health insurance status reporting to the Internal Revenue Service. Additionally, for USPS employees, annuitants, or their family members it may result in OPM's inability to determine eligibility for PSHB coverage.

Public Burden Statement

The public reporting burden to complete this information collection is estimated at 30 minutes per response, including time 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 and expiration date. 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, ATTN: Enrollment and Member Support Program Office at HIPRA@opm.gov. Current information regarding this collection of information -- including all background materials -- can be found at reginfo.gov's Information Collection Review webpage by using the search function to enter either the title of the collection (SF 2809 Health Benefits Election Form) or the OMB Control Number (3206-0160). OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Tables to Help You Complete the SF 2809

QLE Tables 1-5: Find the table that applies to you and use it to find the Qualifying Life Event (QLE) code which allows you to make your enrollment election. Enter the event code in Part B #2 of the form. For additional information about the events listed in the table, please refer to the [Table of Permissible Changes](#).

QLE Table 1: Employees Paying Premiums with Pre-tax Income (Premium Conversion)

Code	Event
1C	Your family status changes so that you gain or lose eligible family members (for example, marriage, divorce, birth or death of a family member, adoption, gain foster child / stepchild, or last child loses eligibility)
1D	You become eligible for coverage as a result of: <ul style="list-style-type: none"> • Reemployment after a break in service of more than three days • Return to pay status from nonpay status, or return to receiving pay sufficient to cover premium withholdings, if coverage terminated
1E	You gain or lose part or all of the Government contribution to premium
1F	You return to your civilian position after serving in uniformed services
1G	You or your covered family member: <ul style="list-style-type: none"> • Begins nonpay status or insufficient pay or • Ends nonpay status or insufficient pay if coverage continued
1H	Your salary as a temporary employee is insufficient to cover premium withholdings
1I	You or your covered family member enrolled in an FEHB/PSHB health maintenance organization (HMO) moves or becomes employed outside the geographic area from which the FEHB/PSHB carrier accepts enrollments or, if already outside the area, moves further from this area
1J	You transfer from a post of duty within the United States to a post of duty outside the United States, or reverse
1K	You leave Federal service when you or your spouse is pregnant
1L	You become entitled to Medicare
1M	You or your eligible family member loses coverage under FEHB/PSHB or another group insurance plan including the following: <ul style="list-style-type: none"> • Loss of coverage under another FEHB/PSHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment • Loss of coverage due to termination of membership in employee organization sponsoring the FEHB/PSHB plan. • Loss of coverage under another Federally-sponsored health benefits program, including: TRICARE, Medicare, Indian Health Service • Loss of coverage under Medicaid or similar state-sponsored program of medical assistance for the needy • Loss of coverage under a non-Federal health plan, including foreign, state or local government, private sector • Loss of coverage due to change in worksite or residence (Employees in an FEHB/PSHB HMO, also see 1I)
1N	You lose coverage under a non-Federal group health plan because you move out of the commuting area to accept another position and your non-Federally employed spouse terminates employment to accompany you
1O	You or your eligible family member loses coverage due to discontinuance in whole or part of an FEHB/PSHB plan
1P	You or your eligible family member gains coverage under FEHB/PSHB or another group insurance plan, including the following: <ul style="list-style-type: none"> • Medicare (Employees who become eligible for Medicare and want to change plans or options, see 1L.) • TRICARE for Life, due to enrollment in Medicare. • TRICARE due to change in employment status, including: (1) entry into active military service, (2) retirement from reserve military service under Chapter 67, title 10. • Medicaid or similar state-sponsored program of Medical assistance for the needy • Health insurance acquired due to change of worksite or residence that affects eligibility for coverage • Health insurance acquired due to spouse's or dependent's change in employment status (includes state, local, or foreign government or private sector employment)
1Q	Your eligible family member's coverage options change under a non-Federal health plan
1R	You or your eligible family member starts receiving assistance under Medicaid or a State Children's Health Insurance Program (CHIP)

QLE Table 2: Annuitants and Compensationers

Code	Event
2B	Your family status changes so that you gain or lose eligible family members (for example, marriage, divorce, birth or death of a family member, adoption, gain foster child / stepchild, or last child loses eligibility)
2C	You suspended your FEHB/PSHB coverage and later involuntarily lost coverage under the non-FEHB program
2D	You want to reenroll in FEHB/PSHB after suspending it (for any reason other than an involuntary loss of coverage)
2E	Your annuity or OWCP compensation was restored
2F	You or your eligible family member loses FEHB/PSHB coverage due to termination, cancellation, or change to Self Plus One or Self Only of the covering enrollment
2G	You or your eligible family member loses coverage under another group insurance plan, for example: <ul style="list-style-type: none"> • 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/PSHB 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
2H	You or your eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB/PSHB plan
2I	You or your covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area
2J	You are employed in an overseas post of duty and retire or die (Compensationers only)
2K	You separate from duty after serving 31 days or more in a uniformed service (Enrolled annuitants only)
2L	You become eligible for Medicare
2M	Your annuity is insufficient to make premium withholdings

QLE Table 3: Former Spouse under Spouse Equity Provision

Code	Event
3C	You add family members who are also eligible family members of the employee or annuitant
3D	You reenroll after suspending 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 later involuntarily lose this coverage
3E	You reenroll after suspending 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 want to reenroll in the FEHB Program for any reason other than an involuntary loss of coverage
3F	You or your covered child loses FEHB/PSHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment
3G	You or your eligible child loses coverage under another group insurance plan, for example: <ul style="list-style-type: none"> • 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/PSHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see 3D and 3E); • Loss of coverage under a non-Federal health plan
3H	You or your eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB/PSHB plan
3I	You or your covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area
3J	You become eligible for Medicare
3K	Your annuity is insufficient to make FEHB premium withholdings

QLE Table 4: Temporary Continuation of Coverage (TCC) for Eligible Former Employees, Former Spouses and Children

Code	Event
4C	Your family status changes so that you gain or lose eligible family members (for example, marriage, divorce, birth or death of a family member, adoption, gain foster child / stepchild, or last child loses eligibility) (This QLE may not be used if you are a former spouse)
4D	You add family members who are also eligible family members of the employee or annuitant (Only for former spouses)
4E	You reenroll after terminating your TCC enrollment for other FEHB/PSHB coverage and lose the other FEHB/PSHB coverage before the TCC period of eligibility (18 or 36 months) expires
4F	You or your eligible family member loses coverage under FEHB/PSHB or another group insurance plan, for example: <ul style="list-style-type: none"> • Loss of coverage under another FEHB/PSHB 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/PSHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-Federal health plan
4G	You or your eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB/PSHB plan
4H	You or your covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area
4I	You become eligible for Medicare

QLE Table 5: Employees Paying Premiums with After-tax Income

Code	Event
5C	Your family status changes so that you gain or lose eligible family members (for example, marriage, divorce, birth or death of a family member, adoption, gain foster child / stepchild, or last child loses eligibility)
5D	Your employment status changes: <ul style="list-style-type: none"> • Reemployment after a break in service of more than 3 days; • Return to pay status following loss of coverage due to expiration of 365 days of LWOP status or termination of coverage during LWOP; • Return to pay sufficient to make withholdings after termination of coverage during a period of insufficient pay; • Restoration to civilian position after serving in uniformed services; • Change from temporary appointment to appointment that entitles employee receipt of Government contribution; • Change to or from part-time career employment
5E	You separate from Federal employment when you or your spouse is pregnant
5F	You transfer from a post of duty within the United States to a post of duty outside the United States, or reverse
5G	You or your eligible family member loses coverage under FEHB/PSHB or another group insurance plan, for example: <ul style="list-style-type: none"> • Loss of coverage under another FEHB/PSHB enrollment due to termination, cancellation, or change to Self Plus One or Self Only of the covering enrollment; • 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/PSHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-Federal health plan
5H	You or your eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB/PSHB plan
5I	You lose coverage under a non-Federal group health plan because you move out of the commuting area to accept another position and your non-federally employed spouse terminates employment to accompany you
5J	You or your covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside the area, moves or becomes employed further from this area
5K	You become eligible for Medicare
5L	You complete one year of continuous service as a temporary employee in accordance with 5 U.S.C. Section 8906a.
5M	Your salary is insufficient to make premium withholdings
5N	You or your eligible family member becomes eligible for assistance under Medicaid or a State Children's Health Insurance Program (CHIP)

Table 6: Family Member Eligibility Documents

Use the table below to find the document(s) you need to submit to prove the eligibility of the family member(s) listed in Part C. You may remove personal financial information and Social Security Numbers before submission. Documents that are not in English must be accompanied by a certified or notarized translation.

Family Member	Acceptable Evidence
Spouse	<ul style="list-style-type: none"> • Married less than 12 months: copy of government-issued marriage certificate. • Married 12 months or more: copy of government-issued marriage certificate and one of the following sets of documents listing spouse: <ul style="list-style-type: none"> o Front page of most recent tax year’s Federal or State tax return; or o Proof of common residency (e.g., utility bill, other household bill, auto registration); and proof of financial interdependency (e.g., shared bank statement, credit card statement, life or auto insurance policy).
Common Law Spouse	<ul style="list-style-type: none"> • A court order or judgment from the initiating state recognizing the marriage; • Your signed declaration. Documents for Common Law Marriage details what the declaration should include. You must also provide one of the following documents that list you and your spouse: <ul style="list-style-type: none"> • Front page of most recent tax year’s Federal or State tax return; • Proof of common residency; or • Proof of financial interdependency.
Child Under Age 26	<p>A copy of any one of the following documents that lists you and your child:</p> <ul style="list-style-type: none"> • Official birth certificate; • Certificate of live birth; • Front page of most recent tax year’s Federal or State tax return with child’s name; • Consular Report of Birth Abroad; • Official paternity test; • Voluntary affidavit of paternity or similar document; or • Court or administrative order (for example, a National Medical Support Notice).
Adopted Child Under Age 26	<p>A copy of any one of the following documents that lists you and your child:</p> <ul style="list-style-type: none"> • Final adoption certificate or decree; • Authorized letter from an adoption placement agency for the purpose of adoption; • Front page of most recent tax year’s Federal or State tax return with child’s name; or • Court or administrative order (for example, a National Medical Support Notice).
Stepchild Under Age 26	<p>A copy of any one of the following documents:</p> <ul style="list-style-type: none"> • Birth certificate, or final adoption certificate/decreed, listing current spouse as parent; • Front page of most recent tax year’s Federal or State tax return with child’s name; or • Court or administrative order (e.g., National Medical Support Notice). • The enrollee must also verify a spouse’s eligibility (see above for required documents), even if not enrolling the spouse in an FEHB plan.
Foster Child Under Age 26	<p>All of the following documents:</p> <ul style="list-style-type: none"> • Child’s official birth certificate; • Certification of foster child status; and • Documentation that shows you provide regular and substantial financial support for the child such as: <ul style="list-style-type: none"> o State or Federal benefits programs listing the child as your dependent; o The front page of your most recent Federal or state tax return listing the child as your dependent; o Canceled checks, money orders, or receipts for periodic payments from you for or on behalf of your child; o Evidence of goods or services which show regular and substantial contributions of considerable value; or o Any other evidence which OPM, in guidance, deems to be sufficient proof of support. • If applicable, include copy of the court order naming you or your spouse as child’s legal guardian
Child Incapable of Self-Support	<p>Medical certificate stating the child is incapable of self-support because of a physical or mental disability that existed before they became age 26 and is expected to continue for more than one year. See FEHB Handbook for details about what the certification should include.</p>