Health Benefits Election Form

Federal Employees Health Benefits Program

For **Employees, Former Spouses Under the Spouse Equity Law, and Individuals Eligible for Temporary Continuation of Coverage**

Form Approved: OMB No. 3206-0160

• *Complete Parts A and G, and Parts B, C, D, E, and F as applicable.*

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

• *Type or print firmly*
• *Sign and date in Part*

Part A - *Fill in this part.*

1. Name *(last, first, middle initial)*	2. Social Security Number	3. Date of birth *(mm/dd/yyyy)*
4. Your home mailing address *(include ZIP code)*	5. Sex ☐ Male ☐ Female	6. Are you now married? ☐ Yes ☐ No
	7. Daytime telephone number *(include area code)*	

Part B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. *(Copy the information requested below from front cover of brochure of the plan you select.)*

Name of plan — Enrollment code

2a. Names of family members *(last, first, middle initial)*	2b. ZIP code	2c. Date of birth *(mm/dd/yyyy)*	2d. Sex	2e. Relationship "code"	2f. Social Security Number *(see instructions)*

3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? ☐ No ☐ Yes → Complete 3b

Name of policyholder *(last, first, middle initial)*

3b. Type of insurance ☐ Medicare *You* ☐ A ☐ B *Your spouse* ☐ A ☐ B ☐ TRICARE (Including CHAMPUS) ☐ Other *(specify name)*

Part C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name
2. Present Plan enrollment code →

Part D - *Event*

1. Event code that permits change *(see Table of Permissible Changes)*
2. Date of event that permits change *(mm/dd/yyyy)*

Part E - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

Part F - *Cancellation*

Place an "X" in the box below if you wish to CANCEL your enrollment.

Present Plan enrollment code

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

Part G - *Fill in this part.*

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*
2. Date *(mm/dd/yyyy)*

Part H - *To be completed by agency*

1. Name and address of employing office *(include ZIP code)*	2. Date received in employing office *(mm/dd/yyyy)*	3. Effective date of action *(mm/dd/yyyy)*	4. SF 2811 report number
	5. Payroll office number	6. Payroll contact and telephone number *(including area code)* ( )	
	7. Personnel contact and telephone number *(including area code)* ( )		
	8. Signature of authorized agency official and telephone number *(including area code)* ( )		

Remarks