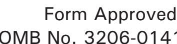


Form Approved:
OMB No. 3206-0141

Health Benefits Registration Form

Instructions for Completing OPM Form 2809
Type or Print Firmly.

Part A. You must complete this part.

Item 1. Give your last name, first name and middle initial.

Item 2. Enter your Social Security Number. (See the Privacy Act and Public Burden Statements on page 2.)

Item 3. Give your date of birth, using numbers to show the month, day, and year, for example, *06/30/1998*.

Item 4. Enter the mailing address you want us to use for all correspondence we send you.

Item 5. Place an "X" in the appropriate box.

Item 6. Place an "X" in the box that signifies your current marital status (if you are separated but not divorced, you are still married).

Item 7. Give the telephone number where you can be reached during normal business hours. Be sure to include the area code.

Part B. Complete this part to enroll or change your enrollment in the FEHB Program.

Item 1. Enter the plan name and appropriate enrollment code from the front cover of the brochure of the plan you want to enroll in or change to. The enrollment code shows the plan and option you are electing and whether you are enrolling for Self Only or Self and Family.

If the plan you want is a prepaid Health Maintenance Organization [HMO], be sure you live in the plan's enrollment area. If it is an employee organization plan, be sure you are eligible to enroll in the plan; you must be or become a member of the plan's sponsoring organization.

Family Members Eligible for Coverage

- Unless you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment include your spouse and your unmarried dependent children under age 22. Eligible children include your legitimate or adopted children; and, if they live in a regular parent-child relationship with you, recognized children born out of wedlock, stepchildren or foster children. A recognized child born out of wedlock also may be included if a judicial determination of support has been obtained or you show that you provide regular and substantial support for the child.

  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 and Family enrollment are the unmarried dependent natural or adopted children under age 22 of both you and your former or deceased spouse.
- Children whose marriage ends before they reach age 22 become eligible for coverage under your Self and Family enrollment from the date the marriage ends until they reach age 22.
- In some cases, an unmarried, disabled child who is over age 22 is eligible for coverage under your Self and Family enrollment if you provide adequate medical certification of a mental or physical disability that existed before his or her 22nd birthday that renders the child incapable of self-support.

Item 2a. Indicate the full name of each covered family member.

Item 2b. Provide the ZIP code if it is different from the enrollee's ZIP code in Part A, item 4.

Item 2c. Provide the family member's date of birth, using numbers to show the month, day, and year.

Item 2d. Indicate M for male or F for female.

Item 2e. Provide the code which indicates the relationship of the eligible family member to you.

1. Spouse
2. Unmarried dependent child under age 22 (including an adopted child)
3. Stepchild, foster child or recognized natural child
4. Unmarried disabled child over age 22 incapable of self-support.

Item 2f. Enter the family member's social security number. (See the Privacy Act and Public Burden Statements on page 2.)

Item 3a. Place an "X" in the appropriate box. If you answer "Yes," enter the name of the policyholder in the space provided and complete item 3b.

Item 3b. If you or your spouse have Medicare, check the Medicare box and show which Parts each of you have.

If you or any covered family member have CHAMPVA, TRICARE, or TRICARE for Life, check that box.

If you or any covered family member have any other group insurance, check that box and give the name of the insurance company.

Part C. You must complete this part if you are changing your enrollment.

Item 1. Enter the name of the plan in which you are presently enrolled.

Item 2. Enter your present enrollment code.

Item 3. Enter the number of the event that permits your change from the table on pages 4 through 8. (Leave this item blank if you are changing from Self and Family to Self Only.)

Item 4. Using numbers, enter the date of the event that permits your change. For Open Season changes, enter the date on which the Open Season begins. (Leave this item blank if you are changing from Self and Family to Self Only.)

Part D. Place an "X" in the box provided if you wish to suspend or cancel your FEHB enrollment. Also enter your present enrollment code in the space provided. ***(Be sure to read the information on page 3 about suspending or cancelling your enrollment.)***

Part E. You must complete this part. Your signature authorizes deductions from your annuity to cover your cost of the enrollment you elect, unless you are making direct payments.

Item 1. Sign your name. Do not print.

Item 2. Enter the date you sign, using numbers to show the month, day and year, for example, *06/30/2003*.

Item 3. Enter your retirement claim number.

Leave ***Part F*** and the ***Remarks*** section blank. They are for agency use only.

Privacy Act and Public Burden Statements

The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program under Chapter 89, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency. While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal government furnish a Social Security Number or tax identification number. This is an amendment to title 31, Section 7701.

We think this form takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management (OPM), OPM Forms Officer, Paperwork Reduction Project (3206-0141), Washington, D.C. 20415-7900. The OMB number, 3206-0141 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

General Information

Dual Enrollment

Generally, you cannot be covered as an annuitant under your own enrollment and as a family member under someone else's enrollment in the Federal Employees Health Benefits (FEHB) Program. However, such dual enrollments may be permitted under certain circumstances in order to:

- Protect the interests of children who otherwise would lose coverage as family members or
- Enable an employee who is under age 22 and covered under a parent's enrollment and who becomes the parent of a child to enroll for Self and Family coverage.

No person (enrollee or family member) is entitled to receive benefits under more than one enrollment in the Program. (Each enrollee must notify his or her plan of the names of the persons to be covered under his or her enrollment who are not covered under the other enrollment.)

Enrollment in a Prepaid Plan

To enroll in a prepaid 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 4 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 + Choice health plan, Medicaid or a similar state-sponsored program of medical assistance for the needy, CHAMPVA, TRICARE, or TRICARE for Life, you will be eligible to enroll in the FEHB Program if any of the above coverages ends.

Reenrollment Eligibility
You may voluntarily reenroll in the FEHB Program during an annual open season. We will send you an open season package each year with instructions on how to reenroll. If you don't want to reenroll, disregard your open season material.

If you involuntarily lose your Medicare + Choice health plan, Medicaid or a similar state-sponsored plan, CHAMPVA, TRICARE, or TRICARE for Life 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, 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. Former spouses who cancel can never reenroll as former spouses.

Effective Dates of Changes

1. Open Season changes take effect January 1.

2. Non-Open Season changes (except cancellations) take effect the first day of the month following the month in which 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:*** If OPM receives your OPM Form 2809 on or before the 15th of the month, cancellation of your FEHB Program enrollment will take effect at the end of the month. If OPM receives the form after the 15th, your cancellation will take effect at the end of the following month.

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. Dial 202-606-0500 if you are in the local Washington, DC area. 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 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 OPM, 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

Web site: http://www.opm.gov/retire

Email: retire@opm.gov

Table of Permissible Changes in Enrollment for OPM 2809

Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time

Events That Permit Enrollment or Change		Change Permitted			Time Limits
Code	Event	From Not Enrolled to Enrolled	From Self Only to Self and Family	From One Plan or Option to Another	When You Must File Health Benefits Election Form With OPM
2	**Annuitants and Survivor Annuitants**				
2A	Open Season.	No	Yes	Yes	As announced by OPM.
2B	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce. (Enrolled survivor annuitant: a change in family status based on additional family members can only occur if the additional eligible family members are family members of the deceased employee or annuitant.)	No	Yes	Yes	From 31 days before through 60 days after the event.
2C	Reenrollment of annuitant who cancelled FEHB enrollment to enroll in a Medicare + Choice health plan, Medicaid, or similar State-sponsored program and who later was **involuntarily** disenrolled from the Medicare + Choice health plan, Medicaid, or similar State-sponsored program, CHAMPVA, TRICARE, or TRICARE for Life.	May Reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment.
2D	Reenrollment of annuitant who cancelled FEHB enrollment to enroll in a Medicare + Choice health plan, Medicaid, or similar State-sponsored program and who later **voluntarily** disenrolls from the Medicare + Choice health plan, Medicaid, or similar State-sponsored program, CHAMPVA, TRICARE, or TRICARE for Life.	May Reenroll	N/A	N/A	During open season.
2E	Restoration of annuity; for example: • Disability annuitant who was enrolled in FEHB, 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 spouse who received a Basic Employee Death Benefit and who was covered by FEHB immediately before remarriage prior to age 55 may enroll in FEHB upon termination of the remarriage. • 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	Within 60 days after the retirement system mails a notice of insurance eligibility.

Evensts That Permit Enrollment or Change		Change Permitted			Time Limits
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With OPM*
2F	Annuitant or eligible family member loses FEHB coverage due to termination, cancellation, or change to self only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.
2G	Annuitant or eligible family member loses coverage under FEHB or 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	From 31 days before through 60 days after loss of coverage.
2H	Annuitant or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	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	Upon notifying OPM of the move.
2J	Employee in an overseas post of duty retires or dies.	No	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	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	At any time beginning on the 30th day before becoming eligible for Medicare.
2M	Cost of the enrollment exceeds the amount of the annuity.	N/A	No	Yes	OPM will advise annuitant of the options.
2N	Annuitant who applies for postponed Minimum Retirement Age plus 10 years of service (MRA plus 10) annuity under the FERS program.	Yes	N/A	N/A	Within 60 days after OPM mails the former employee a notice of eligibility.
2O	Annuitant or survivor annuitant who is enrolled in the Retired Federal Employees Health Benefits Program wants to enroll in the FEHB Program instead.	Yes	N/A	N/A	Anytime.

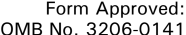
Events That Permit Enrollment or Change		Change Permitted			Time Limits
Code	Event	From Not Enrolled to Enrolled	From Self Only to Self and Family	From One Plan or Option to Another	When You Must File Health Benefits Election Form With OPM
3	**Former Spouse Under the Spouse Equity Provisions**				
3A	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.	Yes	N/A	N/A	Generally, must apply within 60 days after dissolution of marriage. However, if a retiring employee elects to provide a former spouse annuity or insurable interest annuity for the former spouse, the former spouse must apply within 60 days after OPM's notice of eligibility for FEHB. May enroll any time after OPM establishes eligibility.
3B	Open season.	No	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 employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after change in family status.
3D	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare + Choice health plan, Medicaid, or similar State-sponsored program and who later was **involuntarily** disenrolled from the Medicare + Choice health plan, Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment.
3E	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare + Choice health plan, Medicaid, or similar State-sponsored program, and who later **voluntarily** disenrolls from a Medicare + Choice health plan, Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	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	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; • 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 3D and 3E); • Loss of coverage under a non-federal health plan.	N/A	Yes	Yes	From 31 days before through 60 days after loss of coverage.
3H	Former spouse or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	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	Upon notifying OPM of the move.

* Former spouse may change to Self and Family only if family members are also eligible family members of the employee or annuitant.

Events That Permit Enrollment or Change		Change Permitted			Time Limits
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With OPM*
3J	On becoming eligible for Medicare. (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning the 30th day before becoming eligible for Medicare.
3K	Cost of the enrollment exceeds the amount of the annuity.	N/A	No	Yes	OPM will advise former spouse of the options.
4	**Temporary Continuation of Coverage (TCC) for Eligible Former Spouses and Children.**				
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	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	As announced by OPM.
4C	Change in family status (except former spouse); for example, marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after event.
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	From 31 days before through 60 days after event.
4E	Reenrollment of a former employee, 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	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 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	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	During open season, unless OPM sets a different time.

* Former spouse may change to self and family only if family members are also eligible family members of the employee or annuitant.

Events That Permit Enrollment or Change		Change Permitted			Time Limits
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With OPM*
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	Upon notifying OPM of the move.
4I	On becoming eligible for Medicare. (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.



Form Approved:
OMB No. 3206-0141

Federal Employees
Health Benefits Program

Health Benefits Registration Form

Federal Employees Health Benefits Program (FEHBP)

For Use By Annuitants and Former Spouses of Annuitants

❖ Complete Part A and Parts B, C, and D as applicable. Then sign and date Part E.

❖ Type or Print firmly.

Part A - *All who register must fill in this part.*

1. Name *(last, first, middle initial)*
2. Social Security Number
3. Date of birth *(mo./day/yr.)* __ __/__ __/__ __ __ __
4. Your mailing address *(include ZIP code)*
5. Sex ☐ Male ☐ Female
6. Are you now married? ☐ Yes ☐ No
7. Telephone number *(include area code)* (   )

Part B - *Fill in this part if you wish to enroll or change your enrollment in the FEHBP.*

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

Name of plan

Enrollment Code ☞

2a. Names of family members	2b. ZIP code	2c. Date of birth	2d. Sex	2e. Relationship to enrollee	2f. Social Security Number
		__ __/__ __/__ __ __ __			
		__ __/__ __/__ __ __ __			
		__ __/__ __/__ __ __ __			
		__ __/__ __/__ __ __ __			

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

3b. Type of insurance: ☐ Medicare *You* ☐ A ☐ B *Your spouse* ☐ A ☐ B ☐ TRICARE *(including CHAMPVA)* ☐ Other private *(specify name)*

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

1. Present plan name *(the plan you are leaving)*
2. Present plan enrollment code ☞
3. Number of event that permits change
4. Date of event that permits change __ __/__ __/__ __ __ __

Part D - *Fill in this part if you wish to Suspend/Cancel your enrollment in the FEHBP. See page 3 of the instructions.*

My plan enrollment code is

I elect to suspend or cancel my enrollment and have initialed the appropriate box below.

☐ I will be covered under the FEHB enrollment of — Name/Social Security Number

☐ I am covered by a Medicare + Choice health plan, Medicaid or a similar state-sponsored program of medical assistance for the needy. I am enclosing evidence of my coverage.

☐ I will be using CHAMPVA, TRICARE, or TRICARE for Life (enrollees over age 65 with Medicare Parts A and B). I am enclosing copies of my CHAMPVA authorization card or my Uniformed Services identification card and, if over age 65, my Medicare card showing Parts A and B.

☐ I am cancelling my enrollment for reasons other than the three situations shown above. **I understand I can never reenroll in the FEHBP.**

Part E - *All who register or cancel must 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
3. Retirement Claim Number

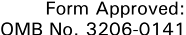
Part F - *To be completed by OPM.*

1. Name and address

U.S. Office of Personnel Management
Office of Retirement Programs
Washington, DC 20415

2. Date received in OPM
3. Effective date of enrollment change shown in Part B or Part D.
4. Effective date of enrollment change shown in Part C
5. Payroll Office Number **24 90 0002**
6. Signature of authorized agency official
7. Date

Remarks *(For use only by agency)*



Health Benefits Registration Form

Federal Employees Health Benefits Program (FEHBP)

For Use By Annuitants and Former Spouses of Annuitants

❖ Complete Part A and Parts B, C, and D as applicable. Then sign and date Part E.

❖ Type or Print firmly.

Part A - *All who register must fill in this part.*

1. Name *(last, first, middle initial)*	2. Social Security Number	3. Date of birth *(mo./day/yr.)* _ _/_ _/_ _ _ _
4. Your mailing address *(include ZIP code)*	5. Sex ☐ Male ☐ Female	6. Are you now married? ☐ Yes ☐ No
	7. Telephone number *(include area code)* ( )	

Part B - *Fill in this part if you wish to enroll or change your enrollment in the FEHBP.*

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

Name of plan	Enrollment Code ☞

2a. Names of family members	2b. ZIP code	2c. Date of birth	2d. Sex	2e. Relationship to enrollee	2f. Social Security Number
		_ _/_ _/_ _ _ _			
		_ _/_ _/_ _ _ _			
		_ _/_ _/_ _ _ _			
		_ _/_ _/_ _ _ _			

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

3b. Type of insurance: ☐ Medicare — *You* ☐ A ☐ B — *Your spouse* ☐ A ☐ B — ☐ TRICARE *(including CHAMPVA)* — ☐ Other private *(specify name)*

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

1. Present plan name *(the plan you are leaving)*	2. Present plan enrollment code ☞	3. Number of event that permits change	4. Date of event that permits change _ _/_ _/_ _ _ _

Part D - *Fill in this part if you wish to Suspend/Cancel your enrollment in the FEHBP. See page 3 of the instructions.*

My plan enrollment code is ➩

I elect to suspend or cancel my enrollment and have initialed the appropriate box below.

☐ I will be covered under the FEHB enrollment of — Name/Social Security Number

☐ I am covered by a Medicare + Choice health plan, Medicaid or a similar state-sponsored program of medical assistance for the needy. I am enclosing evidence of my coverage.

☐ I will be using CHAMPVA, TRICARE, or TRICARE for Life (enrollees over age 65 with Medicare Parts A and B). I am enclosing copies of my CHAMPVA authorization card or my Uniformed Services identification card and, if over age 65, my Medicare card showing Parts A and B.

☐ I am cancelling my enrollment for reasons other than the three situations shown above. **I understand I can never reenroll in the FEHBP.**

Part E - *All who register or cancel must fill in this part.*

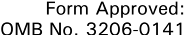
Warning: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both (18 U.S.C. 1001).

1. Your signature *(do not print)*	2. Date	3. Retirement Claim Number

Part F - *To be completed by OPM.*

1. Name and address	2. Date received in OPM	3. Effective date of enrollment change shown in Part B or Part D.
U.S. Office of Personnel Management **Office of Retirement Programs** **Washington, DC 20415**	4. Effective date of enrollment change shown in Part C	5. Payroll Office Number **24 90 0002**
	6. Signature of authorized agency official	7. Date

Remarks *(For use only by agency)*


Form Approved:
OMB No. 3206-0141

Federal Employees
Health Benefits Program

Health Benefits Registration Form

Federal Employees Health Benefits Program (FEHBP)

For Use By Annuitants and Former Spouses of Annuitants

❖ Complete Part A and Parts B, C, and D as applicable. Then sign and date Part E.

❖ Type or Print firmly.

Part A - *All who register must fill in this part.*

1. Name *(last, first, middle initial)*	2. Social Security Number	3. Date of birth *(mo./day/yr.)* __ __/__ __/__ __ __ __
4. Your mailing address *(include ZIP code)*	5. Sex ☐ Male ☐ Female	6. Are you now married? ☐ Yes ☐ No
	7. Telephone number *(include area code)* ( )	

Part B - *Fill in this part if you wish to enroll or change your enrollment in the FEHBP.*

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

Name of plan	Enrollment Code ☞			

2a. Names of family members	2b. ZIP code	2c. Date of birth	2d. Sex	2e. Relationship to enrollee	2f. Social Security Number
		__ __/__ __/__ __ __ __			
		__ __/__ __/__ __ __ __			
		__ __/__ __/__ __ __ __			
		__ __/__ __/__ __ __ __			

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

3b. Type of insurance: ☐ Medicare *You* ☐ A ☐ B *Your spouse* ☐ A ☐ B ☐ TRICARE *(including CHAMPVA)* ☐ Other private *(specify name)*

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

1. Present plan name *(the plan you are leaving)*	2. Present plan enrollment code ☞			3. Number of event that permits change	4. Date of event that permits change __ __/__ __/__ __ __ __

Part D - *Fill in this part if you wish to Suspend/Cancel your enrollment in the FEHBP. See page 3 of the instructions.*

My plan enrollment code is

I elect to suspend or cancel my enrollment and have initialed the appropriate box below.

☐ I will be covered under the FEHB enrollment of Name/Social Security Number

☐ I am covered by a Medicare + Choice health plan, Medicaid or a similar state-sponsored program of medical assistance for the needy. I am enclosing evidence of my coverage.

☐ I will be using CHAMPVA, TRICARE, or TRICARE for Life (enrollees over age 65 with Medicare Parts A and B). I am enclosing copies of my CHAMPVA authorization card or my Uniformed Services identification card and, if over age 65, my Medicare card showing Parts A and B.

☐ I am cancelling my enrollment for reasons other than the three situations shown above. **I understand I can never reenroll in the FEHBP.**

Part E - *All who register or cancel must fill in this part.*

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Part F - *To be completed by OPM.*

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U.S. Office of Personnel Management Office of Retirement Programs Washington, DC 20415	4. Effective date of enrollment change shown in Part C	5. Payroll Office Number **24 90 0002**
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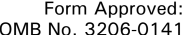
Federal Employees
Health Benefits Program



Form Approved:
OMB No. 3206-0141

Health Benefits Registration Form

Federal Employees Health Benefits Program (FEHBP)

For Use By Annuitants and Former Spouses of Annuitants

❖ Complete Part A and Parts B, C, and D as applicable. Then sign and date Part E.

❖ Type or Print firmly.

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1. Name *(last, first, middle initial)*	2. Social Security Number	3. Date of birth *(mo./day/yr.)* __ __/__ __/__ __ __ __
4. Your mailing address *(include ZIP code)*	5. Sex ☐ Male ☐ Female	6. Are you now married? ☐ Yes ☐ No
	7. Telephone number *(include area code)* ( )	

Part B - *Fill in this part if you wish to enroll or change your enrollment in the FEHBP.*

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

Name of plan	Enrollment Code ☞

2a. Names of family members	2b. ZIP code	2c. Date of birth	2d. Sex	2e. Relationship to enrollee	2f. Social Security Number
		__ __/__ __/__ __ __ __			
		__ __/__ __/__ __ __ __			
		__ __/__ __/__ __ __ __			
		__ __/__ __/__ __ __ __			

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

3b. Type of insurance: ☐ Medicare *You* ☐ A ☐ B *Your spouse* ☐ A ☐ B ☐ TRICARE *(including CHAMPVA)* ☐ Other private *(specify name)*

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

1. Present plan name *(the plan you are leaving)*	2. Present plan enrollment code ☞	3. Number of event that permits change	4. Date of event that permits change __ __/__ __/__ __ __ __

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