



# Notice of Change in Health Benefits Enrollment

## Part A - Identifying Information



1. Name ( <i>Last, first, middle initial</i> )	2. Date of birth	3. Social security number
4. Home address ( <i>including ZIP Code</i> )	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

## Part B - Termination

<input type="checkbox"/>	Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date. <b>Important Notice: You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.</b> See <b>Part B - Termination</b> on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.
If termination is due to death of enrollee enter date of death	Date of death (mo, dy, yr) <input style="width: 150px;" type="text"/>

## Part C - Transfer In

## Part D - Reinstatement

<input type="checkbox"/>	The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.	<input type="checkbox"/>	Your enrollment has been reinstated effective on the date in Part A, item 8, above.
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## Part E - Change in Name of Enrollee

## Part F - Change In Enrollment-Survivor Annuitant

<input type="checkbox"/>	The name under which this enrollment is carried has been changed to:	<input type="checkbox"/>	Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)
Name <input style="width: 200px;" type="text"/>	Date of Birth <input style="width: 100px;" type="text"/>	New Enrollment Code Number <input style="width: 150px; height: 30px; border: 2px solid black; border-radius: 15px;" type="text"/>	
Address (including ZIP Code) if different from Part A, item 4, above.			

## Part G - Remarks

## Part H - Date of Notice

*Note: Instructions for Employing Offices are on the back of Copy 4 of this form.*

Name and address of agency ( <i>including ZIP Code</i> )	Personnel contact and telephone number ( )
	Payroll contact and telephone number ( )
Signature of authorized agency official	Date

## Part B - Termination

*If Part B on the other side of this form is checked, read the following instructions carefully.*

### 31-Day Extension of Coverage

Your enrollment terminates on the date shown in Part A, item 8, on the front of this form. Coverage under your enrollment continues temporarily for 31 days from the date shown. If you, or any covered member of your family, are a patient in a hospital on the 31st day of this temporary extension, benefits of the plan may continue for the rest of that confinement, but not beyond 60 more days.

### Conversion to Nongroup Contract

You may convert your enrollment to a nongroup contract, without evidence of good health. The nongroup contract to which you may convert is one regularly offered by your plan. It may differ from your group plan in benefits, or cost, or both, and you will have to pay the entire cost of the nongroup contract directly to the plan. The nongroup contract is effective on the day after your 31-day extension of coverage ends.

If you are interested in converting to a nongroup contract, write for information to the nearest office of the plan in which you have been enrolled (see the plan's brochure or ask your employing office for the address of the plan's nearest office). The plan will promptly send you an application form and details concerning benefits and rates of the nongroup contract to which you may convert.

### Time Limit on Conversion

Normally, to be eligible for conversion, you must send your written request for information to your plan within 31 days after the date shown in Part H. However, if the date shown in Part H is more than 60 days after the date your enrollment terminates (Part A, item 8), you must forward it to your plan within 91 days after the date shown in Part A, item 8.

If you are prevented by causes beyond your control from submitting a timely request for information about conversion to a nongroup contract, you should write to your plan as soon as possible asking approval of a belated conversion opportunity. Explain fully the circumstances that

prevented earlier action and attach proof of the loss of group coverage (e.g., Standard Form 50 terminating Federal employment). A plan may consider requests filed within 6 months after group eligibility ends. If your plan needs assistance in processing your request, it should contact OPM.

### Temporary Continuation of Coverage

If you are an employee whose enrollment is terminating because you are separating from service (including separation for retirement), you may be eligible to temporarily continue your benefits coverage under the Federal Employees Health Benefits Program after separation. Within 61 days after the date shown in Part A, item 8, on the front of this form, your employing office will formally notify you of your rights regarding temporary continuation of coverage and tell you where you may obtain additional information. You will have 60 days after the later of (1) your date of separation from service, or (2) the date you receive the notice from your employing office in which to elect temporary continuation of coverage.

When your temporary continuation of coverage expires, you will be entitled to the 31-day extension of coverage and the opportunity to convert to a nongroup contract.

### Entry on Active Military Duty

If you elected to terminate your enrollment because you are entering military service, you may convert to a nongroup contract even though your family members are entitled to care under the Uniformed Services Health Benefits Program. If you return to civilian duty in the exercise of reemployment rights, your enrollment will be reinstated effective on the day you return to active duty. If you return to civilian duty not in the exercise of reemployment rights, you must, if eligible for coverage, register again the same as a new employee. If you are an annuitant, your enrollment will be reinstated on the day you are separated from military service. You must notify your retirement system of this event by furnishing a copy of your separation papers.

## Part C - Transfer of Enrollment

*If Part C on the other side of this form is checked, read carefully whichever of the following instructions applies:*

### Transfer of Employment

Your enrollment has been transferred from your previous agency or payroll office to the agency or payroll office shown in Part H. If you are in a prepaid comprehensive medical plan and you left the area served by the plan, you may be able to change to another plan. For details about your right to change plans, check with your employing office.

### Retirement

Your enrollment has been transferred from your employing agency to the retirement system shown in Part H. Your enrollment continues automatically during retirement if you retire on an immediate annuity and you have been enrolled under the Federal Employees Health Benefits Program for the lesser of (1) all your service since your first opportunity to enroll, or (2) the 5 years of service immediately preceding retirement. Your share of the cost of your enrollment will be withheld from your annuity.

### Death

The enrollment of the deceased employee named in Part A has been transferred to the retirement system shown in Part H. If the deceased employee or annuitant was enrolled for self and family at the time of death, and if at least one member of the family is entitled to a survivor annuity (or the widow(er) is entitled to the Basic Employee Death Benefits under FERS), coverage for each family member who was covered by the employee's enrollment continues automatically.

If there is only one eligible survivor, the enrollment will be changed from family coverage to self only. The survivor's share of the cost of the enrollment will be deducted from the annuity. Application for Death Benefits (Standard Form 2800 or the equivalent) should be filed promptly to avoid any question about health benefits coverage. When the survivor annuity is approved, another form like this one will be issued to show that the enrollment is being continued in the survivor's name.

### Employees' Compensation

Your enrollment has been transferred to the Office of Workers' Compensation Programs. Your enrollment continues automatically while you receive monthly compensation from the Office of Workers' Compensation Programs if the Secretary of Labor has held that you are unable to return to duty and if you have been enrolled under the Federal Employees Health Benefits Program for the lesser of (1) all your service since your first opportunity to enroll, or (2) the 5 years of service immediately preceding the start of your compensation. Enrollment of covered family members of a deceased employee or compensationner also continues automatically while they receive monthly compensation, if (1) the deceased employee or compensationner was enrolled for self and family at the time of death, and (2) at least one of the covered family members is entitled to compensation as a surviving beneficiary under the Federal Employees' Compensation Act. The compensationner's or survivor's share of the cost of the enrollment will be deducted from the compensation checks.

***Keep This Form For Your Records***



# Notice of Change in Health Benefits Enrollment

## Part A - Identifying Information

1. Name <i>(Last, first, middle initial)</i>	2. Date of birth	3. Social security number
4. Home address <i>(including ZIP Code)</i>	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

## Part B - Termination

<input type="checkbox"/>	<p>Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.</p> <p><b>Important Notice: You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.</b> See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.</p> <p>If termination is due to death of enrollee enter date of death</p>	<p style="text-align: center;">Date of death (mo, dy, yr)</p> <input style="width: 100%; height: 20px;" type="text"/>
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## Part C - Transfer In

## Part D - Reinstatement

<input type="checkbox"/>	<p>The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.</p>	<input type="checkbox"/>	<p>Your enrollment has been reinstated effective on the date in Part A, item 8, above.</p>
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## Part E - Change in Name of Enrollee

## Part F - Change In Enrollment-Survivor Annuitant

<input type="checkbox"/>	<p>The name under which this enrollment is carried has been changed to:</p> <table style="width: 100%; border: none;"> <tr> <td style="border: none; width: 30%;">Name</td> <td style="border: none; width: 30%;"></td> <td style="border: none; width: 30%;">Date of Birth</td> <td style="border: none;"></td> </tr> <tr> <td colspan="4" style="border: none; padding: 5px;">Address (including ZIP Code) if different from Part A, item 4, above.</td> </tr> </table>	Name		Date of Birth		Address (including ZIP Code) if different from Part A, item 4, above.				<input type="checkbox"/>	<p>Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)</p> <p style="text-align: center; margin-top: 20px;"><b>New Enrollment Code Number</b> <span style="border: 1px solid black; border-radius: 15px; display: inline-block; width: 80px; height: 30px; vertical-align: middle;"></span></p>
Name		Date of Birth									
Address (including ZIP Code) if different from Part A, item 4, above.											

## Part G - Remarks

## Part H - Date of Notice

*Note: Instructions for Employing Offices are on the back of Copy 4 of this form.*

Name and address of agency <i>(including ZIP Code)</i>	Personnel contact and telephone number ( )
	Payroll contact and telephone number ( )
Signature of authorized agency official	Date



Federal Employees  
Health Benefits Program

## Notice of Change in Health Benefits Enrollment

### Part A - Identifying Information

1. Name ( <i>Last, first, middle initial</i> )	2. Date of birth	3. Social security number
4. Home address ( <i>including ZIP Code</i> )	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions.  
Keep this form for your records.

### Part B - Termination

<input type="checkbox"/>	Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date. <b>Important Notice: You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.</b> See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.
If termination is due to death of enrollee enter date of death	Date of death (mo, dy, yr) <input style="width: 150px; height: 20px;" type="text"/>

### Part C - Transfer In

### Part D - Reinstatement

<input type="checkbox"/>	The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.	<input type="checkbox"/>	Your enrollment has been reinstated effective on the date in Part A, item 8, above.
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### Part E - Change in Name of Enrollee

### Part F - Change In Enrollment-Survivor Annuitant

<input type="checkbox"/>	The name under which this enrollment is carried has been changed to:	<input type="checkbox"/>	Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)
Name <input style="width: 250px;" type="text"/>	Date of Birth <input style="width: 100px;" type="text"/>	<div style="display: flex; justify-content: space-between; align-items: center;"> <span>New Enrollment Code Number</span> <input style="width: 150px; height: 30px; border: 2px solid black; border-radius: 15px;" type="text"/> </div>	
Address (including ZIP Code) if different from Part A, item 4, above.			

### Part G - Remarks

### Part H - Date of Notice

*Note: Instructions for Employing Offices are on the back of Copy 4 of this form.*

Name and address of agency ( <i>including ZIP Code</i> )	Personnel contact and telephone number ( )
	Payroll contact and telephone number ( )
Signature of authorized agency official	Date

## Disposition Instructions To Payroll Offices

- Copy 2** - Send to insurance carrier, attached to Transmittal Report to Carrier (SF 2811), **at the earliest possible date**. Under no circumstances should SF 2810s be accumulated for longer than a week, nor should they be delayed to coincide with applicable payroll deductions.
- Copy 3** - Use as payroll action document, if necessary.
- Copy 4** - In cases of death or retirement under the Civil Service Retirement System or the Federal Employees Retirement System, send to the Office of Personnel Management together with the Official Personnel Folder copy of each Health Benefits Registration Form (SF 2809) accepted from the employee including any Medical Certificates attached thereto, Individual Retirement Record (SF 2806 [CSRS] or SF 3100 [FERS]) and any other applicable documents. For other retirement systems (including Office of Workers' Compensation Programs, Department of Labor), send these documents (or the equivalent) to the office administering the system.



# Notice of Change in Health Benefits Enrollment

## Part A - Identifying Information

1. Name <i>(Last, first, middle initial)</i>	2. Date of birth	3. Social security number
4. Home address <i>(including ZIP Code)</i>	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions.  
Keep this form for your records.

## Part B - Termination

<input type="checkbox"/>	Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date. <b>Important Notice: You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.</b> See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.
If termination is due to death of enrollee enter date of death	Date of death (mo, dy, yr)

## Part C - Transfer In

<input type="checkbox"/>	The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.
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## Part D - Reinstatement

<input type="checkbox"/>	Your enrollment has been reinstated effective on the date in Part A, item 8, above.
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## Part E - Change in Name of Enrollee

<input type="checkbox"/>	The name under which this enrollment is carried has been changed to:	
Name	Date of Birth	Address (including ZIP Code) if different from Part A, item 4, above.

## Part F - Change In Enrollment-Survivor Annuitant

<input type="checkbox"/>	Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)
<b>New Enrollment Code Number</b> <span style="border: 1px solid black; border-radius: 15px; display: inline-block; width: 100px; height: 20px; vertical-align: middle;"></span>	

## Part G - Remarks

## Part H - Date of Notice

*Note: Instructions for Employing Offices are on the back of Copy 4 of this form.*

Name and address of agency <i>(including ZIP Code)</i>	Personnel contact and telephone number ( )
	Payroll contact and telephone number ( )
Signature of authorized agency official	Date

# Instructions for Employing Offices

## Purpose of Form

This form covers health benefits actions **except** enrollments, changes from one plan to another, changes of coverage within a plan and cancellations, which are processed on the Health Benefits Registration Form (Standard Form 2809). When an action requires a change in health benefits enrollment, prepare SF 2810 *As Soon As the Effective Date Is Known* and give the appropriate copies to the enrollee and payroll office **Immediately**. Preparation and distribution of copies should not be delayed pending SF 50 action in the case of transfers to another payroll office.

## Prompt Action Required for Conversion

Give this form to the enrollee within 60 days after the date shown in Part A, item 8. To be eligible to convert to a nongroup contract, the enrollee must send a written request for information about conversion to a nongroup contract to his or her plan within 31 days after the date shown in Part H, but not later than 91 days after the date shown in Part A, item 8.

## Completion of Form

### Part A - Identifying Information

1. For items 1, 2, and 6, transcribe from the last SF 2809 or SF 2810, whichever is the most recent.
2. Item 4, use most recent known address.
3. Item 5, use payroll office number of office authorized to process withholdings.
4. Item 8, date as follows for action reported in:
  - B. *Termination* - Last day of pay period in which separation (or other action terminating enrollment) occurs except, when coverage terminates because of completion of 365 days in nonpay status, use the last day of the pay period which includes the 365th day of continuous nonpay status; and when coverage terminates because of military duty not limited to 30 days or less, use date employee is separated, was furloughed or placed on leave of absence for military duty.
  - C. *Transfer In* - Actual date (first day on gaining employing office or retirement system rolls.)
  - D. *Reinstatement* - Actual date.
  - E. *Change In Name Of Enrollee* - Actual date.
  - F. *Change In Enrollment-Survivor Annuitant* - Effective day of sole survivor's annuity.

### Part B - Termination

These most frequently occurring actions terminate enrollment:

- Separated.
- Retired - not eligible to continue enrollment.
- Died - no survivor eligible to continue enrollment.
- Termination of title to annuity or compensation.
- Changed to excluded position or category.
- 365 days nonpay status completed.
- Temporary continuation of coverage expired.

### Part C - Transfer In

Gaining office uses this box to report transfer actions such as:

- Acceptance of transfer from another agency to payroll office number.
- Retired - Acceptance of transfer by retirement system because employee is eligible to continue enrollment as an annuitant.
- Death - Acceptance of transfer by retirement system because survivor is eligible to continue enrollment as a survivor annuitant.
- Transfer accepted by Office of Workers' Compensation Programs.

**Note:** Retirement systems (including OWCP) accepting transfer in, show also in "Remarks" whether enrollment is for an "*Employee Annuitant*" or "*Survivor Annuitant*."

### Part D - Reinstatement

State in "Remarks" reason for any action not applicable to active military duty, such as "Reinstatement of erroneous separation."

### Part E - Change in Name of Enrollee

Use this box only for reporting changes in name where change of coverage within a plan by SF 2809 is not involved. Show date of birth only where enrollment is changed from employee's or annuitant's name to name of survivor annuitant.

### Part F - Change in Enrollment - Survivor Annuitant

Only agencies administering retirement systems will make this determination on the basis of documentary evidence that there is only one survivor annuitant.

### Part G - Remarks

Use this box to bring to the attention of the employee, annuitant, or insurance carrier any pertinent information to clarify or support the action being taken.

### Part H - Date of Notice

Facsimile signature is acceptable. Date as of day of issuance.

## Disposition

- Copy 1** - Deliver (or mail) to employee, annuitant or survivor **at the earliest possible date**, but before 60 days from the date shown in Part A, item 8.
- Copies 2 and 3** - Send to appropriate insurance carrier and payroll office.
- Copy 4** - File in Official Personnel Folder (or its equivalent).