FEHB
Federal Employees Health Benefits Program

Form Approved:
OMB No. 3206-0160

Employee Health Benefits Election Form

Uses for Standard Form (SF) 2809
Use this form to:

Enroll in the FEHB Program; or

Elect not to enroll in the FEHB Program (employees only); or

Change your FEHB enrollment from Self Only to Self and Family and/or from your present plan or option to another plan or option because of an event described in the table beginning on page 6; or

Change your FEHB enrollment from Self and Family to Self Only; or

Cancel your FEHB enrollment.

Who May Use SF 2809

1. Employees eligible to enroll in or currently enrolled in the FEHB Program, including temporary employees eligible under 5 U.S.C. 8906a.

Note: *Civil Service Retirement System (CSRS) and Federal Employees Retirement System (FERS) annuitants and former spouses and children of CSRS/FERS annuitants --* ***Do not use this form.*** *Instead, call the Retirement Information Office toll-free at 1-888-767-6738. Customers within the local calling distance to Washington, DC, should call 202-606-0500.*

2. Former spouses eligible to enroll in or currently enrolled in the FEHB Program under the Spouse Equity law or similar statutes.
3. Individuals eligible for temporary continuation of coverage under the FEHB Program, including:

   Former employees (who separated from service);

   Children who lose FEHB coverage; and

   Former spouses who are not eligible for FEHB under item 2 above.

Instructions for Completing SF 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 5.)

Item 3. Give your date of birth, using numbers to show the month, day, and complete year; e.g., 06/30/1998.

Item 4. Enter your permanent home mailing address.

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 be enrolled in. The enrollment code shows the plan and option you are electing and whether you are enrolling for Self Only or Self and Family.

To enroll in a Health Maintenance Organization (HMO), you must live (or in some cases work) in a geographic area specified by the carrier.

To enroll in an employee organization plan, you must be or become a member of the plan's sponsoring organization, as specified by the carrier.

Your signature in Part G authorizes deductions from your salary, annuity, or compensation to cover your cost of the enrollment you elect in this item, unless you are required to make direct payments to the employing office.

Items 2a through 2f

Complete these items only if your enrollment is for Self and Family. (If you need extra space for additional family members, list them on a separate sheet and attach.)

Item 2a. Indicate the first name and middle initial of each covered family member. Also, give the last name if different from your own.

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

Item 2c. Give each dependent's date of birth, using numbers to show the month, day, and complete year; e.g., 06/30/1998.

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

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

1. Spouse
2. Unmarried dependent child under age 22 (including an adopted child)

3. Stepchild, foster child, or recognized child born out of wedlock

4. Unmarried disabled child over age 22 incapable of self support because of a physical or mental disability that began before age 22.

Item 2f. Please provide Social Security Numbers for your dependents if available. If not available, leave blank; benefits will not be withheld. (See Privacy Act Statement on page 5.)

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 recognized children born out of wedlock, stepchildren or foster children, if they live with you in a regular parent-child relationship. 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 22 years old or older is eligible for coverage under your Self and Family enrollment if you provide adequate medical certification of a mental or physical handicap that existed before his or her 22nd birthday and renders the child incapable of self-support.

Note: *Your employing office (see definition under Where to Obtain FEHB Guides and Brochures on page 3) can give you additional details about family member eligibility including the documentation required for coverage of a disabled child age 22 or older.*

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 has Medicare, check the Medicare box and show which Parts each of you have.

If you or any covered family member has TRICARE (including CHAMPUS), check that box.

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

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

Item 1. Enter the name of the plan you are in now.

Item 2. Enter your present enrollment code.

Part D. You must complete this part if you are newly enrolling or changing based on an event listed in the Table of Permissible Changes in Enrollment beginning on page 6. Do not complete this part if you are cancelling or changing from Self and Family to Self Only.

Item 1. Enter the event code that permits you to enroll or change, from the table beginning on page 6.

Item 2. Enter the date of the event that permits you to enroll or change, using numbers to show month, day, and complete year; e.g., 06/30/1998. For initial enrollment, enter the date you became eligible to enroll (for example, the date your appointment began). For Open Season changes, enter the date on which the Open Season begins.

Part E. Place an "X" in the box provided only if you are an employee and you do not wish to enroll in the FEHB Program. **(Be sure to read the information about electing not to enroll on page 4.)**

Part F. Place an "X" in the box provided only if you wish to cancel your FEHB enrollment. Also enter your present enrollment code in the space provided. **(Be sure to read the information about cancelling your enrollment on page 4.)**

Part G. You must complete this part.

Item 1. Sign your name. Do not print.

Item 2. Enter the date you sign, using numbers to show the month, day and complete year; e.g., 06/30/1998.

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

If You Are Registering for Someone Else

If you are registering for someone else under a written authorization from him or her to do so, sign your name in Part G 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 temporary continuation of coverage as his or her court-appointed guardian, sign your name in Part G and attach evidence of your court-appointed guardianship.

Guides to Federal Employees Health Benefits Plans (FEHB Guides) and Plan Brochures

FEHB Guides contain enrollment, plan, and rate information. Be sure you have the correct guide for your enrollment category since more than one guide is issued. The different categories are:

Employees, non-Postal or Postal

Annuitants in CSRS or FERS or other retirement systems

Temporary Continuation of Coverage enrollees and former spouses under Spouse Equity

Individuals receiving compensation from the Office of Workers' Compensation Programs

Temporary employees eligible for FEHB under 5 U.S.C. 8906a

Visually impaired employees

FEHB Plan brochures contain detailed information about plan benefits and the contractual description of coverage.

Where to Obtain FEHB Guides and Brochures

Your plan will send you its brochure before the beginning of each contract year.

FEHB Guides and plan brochures are available from your employing office.

"Employing office" means the office of an agency or retirement system that is responsible for health benefits actions for an employee, annuitant, former spouse eligible for coverage under the Spouse Equity provisions, or individual eligible for temporary continuation of coverage (TCC).

You can also get copies of plan brochures by contacting the plans directly at the telephone numbers shown in the FEHB Guide. The FEHB Guide also shows which plans have their own website.

The FEHB Guide, plan brochures, and other information, including links to plan websites, are available on the World Wide Web. Visit our website at **http://www.opm.gov/insure**.

Employee Express

Employee Express is an automated system that allows some Federal employees to make changes using a touch-tone telephone, a personal computer or computer kiosk instead of a form. If you are not sure whether you can use Employee Express, call your employing office.

Dual Enrollment

Normally, you are not eligible to enroll if you are covered as a family member under someone else's enrollment in the FEHB Program. However, such dual enrollments may be permitted under certain circumstances in order to:

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 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.)

Temporary Continuation of Coverage (TCC)

While the employing office notifies a former employee of his or her eligibility for temporary continuation of coverage, the employing office must be notified when a child or former spouse becomes eligible.

For the eligible child of an enrollee, the enrollee must notify the employing office within 60 days after the qualifying event occurs; e.g., child reaches age 22.

For the eligible former spouse of an enrollee, the enrollee or the former spouse must notify the employing office within 60 days after the former spouse's change in status; e.g., the date of the divorce.

An individual eligible for temporary continuation of coverage who wants to continue FEHB coverage may choose any plan (for which he or she is eligible), option, and type of enrollment. The time limits for a former employee, child, or former spouse to file the SF 2809 with the employing office appear in event number 4A in the table on page 8.

Note: *If someone other than the enrollee notifies the employing office of the child's eligibility for temporary continuation of coverage within the specified time period, the child's opportunity to file the SF 2809 ends 60 days after the qualifying event. If someone other than the enrollee or the former spouse notifies the employing office of the former spouse's eligibility for continued coverage within the specified time period, the former spouse's opportunity to file the SF 2809 ends 60 days after the change in status.*

Effective Dates

Except for open season, most enrollments and changes of enrollments are effective on the first day of the pay period after the employing office receives the SF 2809 or other appropriate request. Your employing office can give you the specific date on which your enrollment or enrollment change will take effect.

Note 1: *If you are changing your enrollment from Self and Family to Self Only so that your spouse can enroll for Self Only, you should coordinate the effective date of your spouse's enrollment with the effective date of your enrollment change to avoid a gap in your spouse's coverage.*

Note 2: *If you are cancelling your enrollment and intend to be covered under someone else's enrollment at the time you cancel, you should coordinate the effective date of your cancellation with the effective date of your new coverage to avoid a gap in your coverage.*

Cancellation of Enrollment

You may cancel your enrollment at any time. (If you are a United States Postal Service employee, consult your employing office or information provided by your agency.) However, if you cancel, neither you nor any family member covered by your enrollment are entitled to a 31-day temporary extension of coverage, or to convert to an individual, nongroup policy. Moreover, family members who lose coverage because of your cancellation are not eligible for temporary continuation of coverage. (Be sure to read the additional information below about cancelling your enrollment.)

Employees Who Elect Not to Enroll or Who Cancel Their Enrollment

To be eligible for an FEHB enrollment after you retire, you must retire:

Under a retirement system for Federal civilian employees, and

On an immediate annuity.

In addition, you must be currently enrolled in a plan under the FEHB Program and must have been enrolled (or covered as a family member) in a plan under the Program for:

The 5 years of service immediately before retirement (i.e., commencing date of annuity entitlement), or

If fewer than 5 years, all service since your first opportunity to enroll. (Generally, your first opportunity to enroll is within 60 days after your first appointment [in your Federal career] to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

If you do not enroll at your first opportunity or if you cancel your enrollment, you may later enroll or reenroll only under the circumstances explained in the table beginning on page 6. Some employees delay their enrollment or reenrollment until they are nearing 5 years before retirement in order to qualify for FEHB coverage as a retiree; however, there is always the risk that they will retire earlier than expected and not be able to meet the 5-year requirement for continuing FEHB coverage into retirement. Please understand that when you elect not to enroll or cancel your enrollment **you are voluntarily accepting this risk.** An alternative would be to enroll in or change to a lower cost plan so that you meet the requirements for continuation of your FEHB enrollment after retirement.

Note for temporary employees eligible for FEHB under 5 U.S.C. 8906a: *Your decision not to enroll or to cancel your enrollment will **not** affect your future eligibility to continue FEHB enrollment after retirement.*

Annuitants Who Cancel Their Enrollment

Generally, you cannot reenroll as an annuitant unless you are continuously covered as a family member under another person's enrollment in the FEHB Program during the period between your cancellation and reenrollment. Your employing office can advise you on events that allow eligible annuitants to reenroll.

If you cancel your enrollment because you are covered under another FEHB enrollment, you can reenroll from 31 days before through 60 days after you lose that coverage under the other enrollment.

If you cancel your FEHB enrollment because you are enrolling in a Medicare HMO, or Medicaid or similar State-sponsored program, you can reenroll in the FEHB Program if your coverage ends. If your coverage ends **involuntarily,** you can reenroll 31 days before through 60 days after loss of coverage. If your coverage ends **voluntarily** because you disenroll, you can reenroll during the next open season.

If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.

Former Spouses (Spouse Equity) Who Cancel Their Enrollment

Generally, if you cancel your enrollment in the FEHB Program, you cannot reenroll as a former spouse. However, if you stop the enrollment because you acquire other FEHB coverage, your right to FEHB coverage under the spouse equity provisions continues. You may reenroll as a former spouse when the other FEHB coverage ends.

If you cancel your enrollment because you are covered under another FEHB enrollment, you can reenroll from 31 days before through 60 days after you lose that coverage under the other enrollment.

If you cancel your FEHB enrollment because you are enrolling in a Medicare HMO, or Medicaid or similar State-sponsored program, you can reenroll in the FEHB Program if your coverage ends. If your coverage ends **involuntarily,** you can reenroll 31 days before through 60 days after loss of coverage. If your coverage ends **voluntarily** because you disenroll, you can reenroll during the next open season.

If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.

Temporary Continuation of Coverage Enrollees Who Cancel Their Enrollment

If you cancel your TCC enrollment, you cannot reenroll. Your family members who lose coverage because of your cancellation cannot enroll for TCC in their own right nor can they convert to a nongroup policy. However, family members who are Federal employees or annuitants may enroll in the FEHB Program when you cancel your coverage if they are eligible for FEHB coverage in their own right.

Note 1: *If you become covered by a regular enrollment in the FEHB Program, either in your own right or under the enrollment of someone else, your TCC enrollment is suspended. You will need to send documentation of the new enrollment to the employing office maintaining your TCC enrollment so that they can stop the TCC enrollment. If your new FEHB coverage stops before the TCC enrollment would have expired, the TCC enrollment can be reinstated for the remainder of the original eligibility period (18 months for separated employees).*

Note 2: *Former spouses (spouse equity) and temporary continuation of coverage enrollees who fail to pay their premiums within specified time frames are considered to have voluntarily cancelled their enrollment.*

Explanation of Table of Permissible Changes in Enrollment

The table on pages 6 through 9 illustrates when an employee, former spouse, or person eligible for TCC may enroll or change enrollment. The table shows those permissible events that are found in the regulations at 5 CFR Part 890.

The table has been organized by enrollee category. Each category is designated by a number, which identifies the enrollee group, as follows:

1 Employees

3 Former spouses

4 TCC enrollees

Note: *Category 2 has been reserved for annuitants (other than CSRS/FERS annuitants), including individuals receiving monthly compensation from the Office of Workers' Compensation Programs, who will be using another edition of this form, SF 2809-1.*

Following each number is a letter, which identifies a specific permissible event; for example, the event code "1A" refers to an employee's initial opportunity to enroll.

At Part D of the SF 2809, Health Benefits Election Form, you must designate your two-character event code (for example, 1A) and the date of the event using numbers to show month, day, and complete year; e.g., 06/30/1998.

Privacy Act Statement

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 a 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.

We request that you provide your Social Security Number so that it may be used as your individual identifier in the Federal Employees Health Benefits Program. 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. Failure to furnish the requested information may result in OPM's inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

Agencies other than the Office of Personnel Management may have further routine uses for disclosure of information from the records system in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

Public Burden Statement

We think this form takes an average of 30 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, Reports and Forms Manager, (3206-0160), Washington, D.C. 20415-7900. The OMB number, 3206-0160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Table of Permissible Changes in Enrollment for SF 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 Your Employing Office*
1	**EMPLOYEE**				
1A	Initial opportunity to enroll.	Yes	N/A	N/A	Within 60 days after becoming eligible.
1B	Open Season.	Yes	Yes	Yes	As announced by OPM.
1C	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce.	Yes	Yes	Yes	From 31 days before through 60 days after event.
1D	Change in employment status; for example: • Reemployment after a break in service of more than three 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.	Yes	Yes	Yes	Within 60 days of employment status change.
1E	Separation from Federal employment when the employee or employee's spouse is pregnant.	Yes	Yes	Yes	Enrollment or change must occur during final pay period of employment.
1F	Transfer from a post of duty within the United States to a post of duty outside the United States, or reverse.	Yes	Yes	Yes	From 31 days before leaving old post through 60 days after arriving at new post.
1G	Employee 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; • 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.	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
1H	Employee 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.

* If you are a United States Postal Service employee, these rules may be different. Consult your employing office or information provided by your agency.

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 Your Employing Office*
1I	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-federally employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area through 180 days after arriving in the new commuting area.
1J	Employee or 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.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
1K	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.
1L	Temporary employee completes one year of continuous service in accordance with 5 U.S.C. Section 8906a.	Yes	N/A	N/A	Within 60 days after becoming eligible.
1M	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Within 60 days after receiving notice from employing office.
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, the Intelligence Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).	Yes	N/A	N/A	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 employing office 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 sponsored Coordinated Care Plan (Medicare HMO), Medicaid, or similar State-sponsored program and who later was **involuntarily** disenrolled from the Medicare HMO, Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment.

* 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 Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
3E	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare-sponsored Coordinated Care Plan (Medicare HMO), Medicaid, or similar State-sponsored program and who later **voluntarily** disenrolls from the Medicare-sponsored Coordinated Care Plan (Medicare HMO), 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 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.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
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	Former spouse's annuity is insufficient to make FEHB withholdings for plan in which enrolled.	No	No	Yes	Retirement System will advise former spouse of options.
4	**TEMPORARY CONTINUATION OF COVERAGE (TCC) FOR ELIGIBLE FORMER EMPLOYEES, FORMER SPOUSES, AND CHILDREN.**				
4A	Opportunity to enroll for continued coverage under TCC provisions: • Former employee • Former spouse • Child who ceases to qualify as a family member	 Yes Yes Yes	 Yes N/A N/A	 Yes N/A N/A	Within 60 days after the qualifying event, or receiving notice of eligibility, whichever is later.
4B	Open season: • Former employee • Former spouse • Child who ceases to qualify as a family member	 No No No	 Yes Yes* Yes	 Yes Yes Yes	As announced by OPM.

* 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 Your Employing Office*
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.
4H	Enrollee or 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.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
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.

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

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

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.*
- *Type or print firmly*
- *Sign and date in Part*

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

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*

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Remarks

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

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

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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*

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- *Type or print firmly*
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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.*

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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*

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Remarks