



Health Benefits Election Form

Part A - Enrollee and Family Member Information *(For additional family members use a separate sheet and attach.)*

1. Enrollee name <i>(last, first, middle initial)</i>		2. Social Security number	3. Date of birth <i>(mm/dd/yyyy)</i>	4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	5. Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Home mailing address <i>(including ZIP Code)</i> -----			7. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		8. Medicare Claim Number
			9. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 10 below. <input type="checkbox"/> No		
10. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: <i>Name of other insurance:</i> _____ <i>Policy number:</i> _____					
<input type="checkbox"/> FEHB <i>An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.</i>					
11. Name of family member <i>(last, first, middle initial)</i>		12. Social Security number	13. Date of birth <i>(mm/dd/yyyy)</i>	14. Sex <input type="checkbox"/> M <input type="checkbox"/> F	15. Relationship code
16. Address <i>(if different from enrollee)</i> -----			17. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		18. Medicare Claim Number
			19. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 20 below. <input type="checkbox"/> No		
20. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: <i>Name of other insurance:</i> _____ <i>Policy number:</i> _____					
<input type="checkbox"/> FEHB <i>An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.</i>					
21. Email address <i>(if home address is different from enrollee's)</i>			22. Preferred telephone number <i>(if home address is different from enrollee's)</i>		
23. Name of family member <i>(last, first, middle initial)</i>		24. Social Security number	25. Date of birth <i>(mm/dd/yyyy)</i>	26. Sex <input type="checkbox"/> M <input type="checkbox"/> F	27. Relationship code
28. Address <i>(if different from enrollee)</i> -----			29. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		30. Medicare Claim Number
			31. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 32 below. <input type="checkbox"/> No		
32. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: <i>Name of other insurance:</i> _____ <i>Policy number:</i> _____					
<input type="checkbox"/> FEHB <i>An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.</i>					
33. Email address <i>(if home address is different from enrollee's)</i>			34. Preferred telephone number <i>(if home address is different from enrollee's)</i>		
35. Name of family member <i>(last, first, middle initial)</i>		36. Social Security number	37. Date of birth <i>(mm/dd/yyyy)</i>	38. Sex <input type="checkbox"/> M <input type="checkbox"/> F	39. Relationship code
40. Address <i>(if different from enrollee)</i> -----			41. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		42. Medicare Claim Number
			43. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 44 below. <input type="checkbox"/> No		
44. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: <i>Name of other insurance:</i> _____ <i>Policy number:</i> _____					
<input type="checkbox"/> FEHB <i>An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.</i>					
45. Email address <i>(if home address is different from enrollee's)</i>			46. Preferred telephone number <i>(if home address is different from enrollee's)</i>		

Part B - FEHB Plan You Are Currently Enrolled In (if applicable) 1. Plan name 2. Enrollment code		Part C - FEHB Plan You Are Enrolling In or Changing To 1. Plan name 2. Enrollment code	
Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2) 1. Event code 2. Date of event		Part E - Election NOT to Enroll (Employees Only) <input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
Part F - Cancellation of FEHB <input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		Part G - Suspension of FEHB (Annuitants/Former Spouses Only) <input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
Part H - Signature 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)	
3. Email address		4. Preferred telephone number	
Part I - To be completed by agency or retirement system REMARKS			
1. Date received (mm/dd/yyyy)		2. Effective date of action (mm/dd/yyyy)	
4. Name and address of agency or retirement system		3. Personnel telephone number	
		5. Authorizing official (please print)	
		6. Signature of authorized agency official	
7. Payroll office number		8. Payroll office contact (please print)	
		9. Payroll telephone number	