FEHB
Federal Employees Health Benefits Program

Health Benefits Election Form

OMB Approval 3206-0160

For Use By Annuitants and Former Spouses of Annuitants

Use this form to enroll, elect not to enroll, change, suspend or cancel your health insurance coverage in the Federal Employees Health Benefits Program (FEHB Program) which includes FEHB and Postal Service Health Benefits (PSHB) plans. Read the instructions carefully to understand your election and to find the codes referenced in this form.

Part A - Enrollee Information

1. Enrollee name *(last, first, middle initial)*
2. Social Security Number
3. Date of birth *(mm/dd/yyyy)*
4. Sex
   ○ Male ○ Female
5. Are you married?
   ○ Yes ○ No
6. Mailing address *(including ZIP Code)*
7. If you are covered by Medicare, check all that apply.
   ○ A ○ B ○ C ○ D
8. Medicare Beneficiary Identifier
9. Are you covered by insurance other than Medicare?
   ○ Yes, indicate in item 10 below. ○ No
10. Indicate the type(s) of other insurance

○ TRICARE

○ FEHB/PSHB — *An FEHB/PSHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB/PSHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB/PSHB enrollment. See instructions for item 10 on page 1.*

○ Other *Name of other insurance:* _____ *Policy Number:* _____

(Postal Service Annuitants Only) Are you claiming an exception to the Medicare Part B enrollment requirement? If so, please select one of the exceptions and attach the required supporting documentation.

○ Enrolled in VA healthcare benefits
○ Eligible for health services from IHS
○ Resides abroad
○ Enrollee not required to enroll
○ Medicare A - Section 1818/1818A *(uncommon)*

11. Email address
12. Preferred telephone number

Part B - Family Member Information *(Please duplicate this section as needed for any additional family members.)*

List all eligible family members you want covered by your enrollment. Your family member's enrollment is not complete without the required eligibility documents. See *https:www.opm.gov/healthcare-insurance/healthcare/eligibility/* for more information on required documents. You must submit a new OPM 2809 to remove any family member who becomes ineligible.

13. Name of family member *(last, first, middle initial)*
14. Social Security Number
15. Date of birth *(mm/dd/yyyy)*
16. Sex
    ○ Male ○ Female
17. Relationship code
    01 - Spouse
18. Address *(if different from enrollee)*
19. If this family member is covered by Medicare, check all that apply.
    ○ A ○ B ○ C ○ D
20. Medicare Beneficiary Identifier
21. Is this family member covered by insurance other than Medicare?
    ○ Yes, indicate in item 22 below. ○ No
22. Indicate the type(s) of other insurance

○ TRICARE

○ FEHB/PSHB — *An FEHB/PSHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB/PSHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB/PSHB enrollment. See instructions for item 22 on page 2.*

○ Other *Name of other insurance:* _____ *Policy Number:* _____

(Postal Service Annuitants Only) Is your family member claiming an exception to the Medicare Part B enrollment requirement? If so, please select one of the exceptions and attach the required supporting documentation.

○ Enrolled in VA healthcare benefits
○ Eligible for health services from IHS
○ Resides abroad
○ Enrollee not required to enroll
○ Medicare A - Section 1818/1818A *(uncommon)*

23. Email address
24. Preferred telephone number

(Part B continued on page 2)

25. Name of family member *(last, first, middle initial)*

26. Social Security Number

27. Date of birth *(mm/dd/yyyy)*

28. Sex

○ Male ○ Female

29. Relationship code

01 - Spouse

30. Address *(if different from enrollee)*

31. If this family member is covered by Medicare, check all that apply.

○ A ○ B ○ C ○ D

32. Medicare Beneficiary Identifier

33. Is this family member covered by insurance other than Medicare?

○ Yes, indicate in item 34 below. ○ No

34. Indicate the type(s) of other insurance

○ TRICARE

○ FEHB/PSHB *An FEHB/PSHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB/PSHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB/PSHB enrollment. See instructions for item 22 on page 2.*

○ Other *Name of other insurance:* _____ *Policy Number:* _____

(Postal Service Annuitants Only) Is your family member claiming an exception to the Medicare Part B enrollment requirement? If so, please select one of the exceptions and attach the required supporting documentation.

○ Enrolled in VA healthcare benefits
○ Eligible for health services from IHS
○ Resides abroad
○ Enrollee not required to enroll
○ Medicare A - Section 1818/1818A *(uncommon)*

35. Email address

36. Preferred telephone number

37. Name of family member *(last, first, middle initial)*

38. Social Security Number

39. Date of birth *(mm/dd/yyyy)*

40. Sex

○ Male ○ Female

41. Relationship code

01 - Spouse

42. Address *(if different from enrollee)*

43. If this family member is covered by Medicare, check all that apply.

○ A ○ B ○ C ○ D

44. Medicare Beneficiary Identifier

45. Is this family member covered by insurance other than Medicare?

○ Yes, indicate in item 46 below. ○ No

46. Indicate the type(s) of other insurance

○ TRICARE

○ FEHB/PSHB *An FEHB/PSHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB/PSHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB/PSHB enrollment. See instructions for item 22 on page 2.*

○ Other *Name of other insurance:* _____ *Policy Number:* _____

(Postal Service Annuitants Only) Is your family member claiming an exception to the Medicare Part B enrollment requirement? If so, please select one of the exceptions and attach the required supporting documentation.

○ Enrolled in VA healthcare benefits
○ Eligible for health services from IHS
○ Resides abroad
○ Enrollee not required to enroll
○ Medicare A - Section 1818/1818A *(uncommon)*

47. Email address

48. Preferred telephone number

Part C - FEHB/PSHB Plan You Are Currently Enrolled In *(if applicable)*

Enrollment code

Part D - FEHB/PSHB Plan You Are Enrolling In or Changing To *(if applicable)*

Enrollment code

Part E - Event That Permits You to Enroll, Change, or Cancel *(see pages 3-4)*

1. Event code

2. Date of event *(mm/dd/yyyy)*

Part F - Election to Suspend/Cancel

(Complete this part if you wish to suspend/cancel your enrollment in the FEHB Program. See pages 3-4 of the instructions.)

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

☐ I am cancelling my FEHB Program enrollment to be covered under the FEHB Program enrollment of:

Name	*Social Security Number*

☐ I am suspending my FEHB Program enrollment because I am covered by Medicare Advantage plan, Medicaid or a similar state-sponsored program of medical assistance for individuals with limited income and resources. I am enclosing evidence of my coverage.

☐ I am suspending my FEHB Program enrollment because I am covered under 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 suspending my FEHB Program enrollment because I am covered by Peace Corps volunteer health benefits. I am enclosing evidence of my coverage.

☐ I am cancelling my enrollment for reasons other than the situations listed above. ***I understand I can never reenroll in the FEHB Program.***

Part G - Signature *(you must complete this part)*

WARNING: ***Any intentionally false statement on 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. Retirement Claim Number

4. Email Address	5. Preferred telephone number

Part H - To be Completed by OPM

1. Name and address	2. Date received in OPM	3. Effective date of action	4. Payroll office number
U.S. Office of Personnel Management **Retirement Services** **Washington, D.C. 20415**			**24 90 0002**
	5. Signature of authorized agency official		6. Date *(mm/dd/yyyy)*

Remarks *(For use by OPM only.)*