Federal Employees Health Benefits Program

Form Approved: OMB No. 3206-0160

Health Benefits Election Form

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

1. Enrollee name *(last, first, middle initial)*	2. Social Security number	3. Date of birth *(mm/dd/yyyy)*	4. Sex	5. Are you married?
Employee-Name	**Employee-SSN**	**Birth-Date**	En M En F	Ma Yes Ma No

6. Home mailing address *(including ZIP Code)*	7. If you are covered by Medicare, check all that apply.	8. Medicare Claim Number
Employee-Address1	En A En B En D	**Employee-Medicare-ClaimNo**
Employee-Address2	9. Are you covered by insurance other than Medicare? En Yes, indicate in item 10 below. En No	

10. Indicate the type(s) of other insurance:

En TRICARE En Other: *Name of other insurance:* **Employee-Insurance-Name** *Policy number:* **Employee-Insurance-Policy-No**

En FEHB *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.*

11. Name of family member *(last, first, middle initial)*	12. Social Security number	13. Date of birth *(mm/dd/yyyy)*	14. Sex	15. Relationship code
Member1-Name	**Member1-SSN**	**Member1-Birth-Date**	Me M Me F	**Member1-Relationship-**

16. Address *(if different from enrollee)*	17. If you are covered by Medicare, check all that apply.	18. Medicare Claim Number
Member1-Address1	Me A Me B Me D	**Member1-Medicare-ClaimNo**
Member1-Address2	Me Me No	

20. Indicate the type(s) of other insurance:

Me TRICARE Me Other: *Name of other insurance:* **Member1-Insurance-Name** *Policy number:* **Member1-Policy-No**

Me FEHB *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.*

21. Email address *(if home address is different from enrollee's)*	
Member1-Email	**Member1-Phone**

	24. Social Security number	25. Date of birth *(mm/dd/yyyy)*	26. Sex	27. Relationship code
Member2-Name	**Member2-SSN**	**Member2-Birth-Date**	Me M Me F	**Member2-Relationship-**

28. Address *(if different from enrollee)*	29. If you are covered by Medicare, check all that apply.	30. Medicare Claim Number
Member2-Address1	Me A Me B Me D	**Member2-Medicare-ClaimNo**
Member2-Address2	Me Yes, indicate in item 32 below. Me No	

32. Indicate the type(s) of other insurance:

Me TRICARE Me Other: *Name of other insurance:* **Member2-Insurance-Name** *Policy number:* **Member2-Policy-No**

Me FEHB *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.*

33. Email address *(if home address is different from enrollee's)*	34. Preferred telephone number *(if home address is different from enrollee's)*
Member2-Email	**Member2-Phone**

35. Name of family member *(last, first, middle initial)*	36. Social Security number	37. Date of birth *(mm/dd/yyyy)*	38. Sex	39. Relationship code
Member3-Name	**Member3-SSN**	**Member3-Birth-Date**	Me M Me F	**Member3-Relationship-**

40. Address *(if different from enrollee)*	41. If you are covered by Medicare, check all that apply.	42. Medicare Claim Number
Member3-Address1	Me A Me B Me D	**Member3-Medicare-ClaimNo**
Member3-Address2	Me Me	

Me Me *Name of other insurance:* **Member3-Insurance-Name** *Policy number:* **Member3-Policy-No**

Me FEHB *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.*

45. Email address *(if home address is different from enrollee's)*	
Member3-Email	**Member3-Phone**

(continued on the reverse)

Part B - FEHB Plan You Are Currently Enrolled In ***(if applicable)***

1. Plan name	2. Enrollment code
Present-Plan-Name	**Present-Enrollmen**

Part C - FEHB Plan You Are Enrolling In or Changing To

1. Plan name	2. Enrollment code
New-Plan-Name	**New-Plan-Code**

Part D - Event That Permits You To Enroll, Change, or Cancel ***(see page 2)***

1. Event code	2. Date of event
Event-Code	**Event-Date**

Part E - Election NOT to Enroll ***(Employees Only)***

W I do NOT want to enroll in the FEHB Program.

My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.

Part F - Cancellation of FEHB

Ca I CANCEL my enrollment.

My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.

Part G - Suspension of FEHB ***(Annuitants/Former Spouses Only)***

Su I SUSPEND my enrollment.

My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.

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)*
Employee-Signature	**Signature-Date**
3. Email address	4. Preferred telephone number
Employee-Email	**Daytime-Telephone**

Part I -To be completed by agency or retirement system

REMARKS

Remarks

1. Date received *(mm/dd/yyyy)*	2. Effective date of action *(mm/dd/yyyy)*	3. Personnel telephone number
Received-Date	**Effective-Date**	**Personnel-Telephone**
4. Name and address of agency or retirement system **Agency-System-Name** **Agency-System-Address1** **Agency-System-Address2**		5. Authorizing official *(please print)* **Authorizing-Official** 6Signature of authorized agency official **Authorized-Official-Signature**
7. Payroll office number	8. Payroll office contact *(please print)*	9. Payroll telephone number
Payroll-Number	**Payroll-Contact**	**Payroll-Telephone**