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 ☐ M ☐ F
5. Are you married? ☐ Yes ☐ No
6. Home mailing address *(including ZIP Code)*
7. If you are covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
8. Medicare Claim Number
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 ☐ Other: *Name of other insurance:* _____ *Policy number:* _____
☐ 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 ☐ M ☐ F
15. Relationship code
16. Address *(if different from enrollee)*
17. If you are covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
18. Medicare Claim Number
19. Are you covered by insurance other than Medicare? ☐ Yes, indicate in item 20 below. ☐ No
20. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other: *Name of other insurance:* _____ *Policy number:* _____
☐ 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)*
22. Preferred telephone number *(if home address is different from enrollee's)*

23. Name of family member *(last, first, middle initial)*
24. Social Security number
25. Date of birth *(mm/dd/yyyy)*
26. Sex ☐ M ☐ F
27. Relationship code
28. Address *(if different from enrollee)*
29. If you are covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
30. Medicare Claim Number
31. Are you covered by insurance other than Medicare? ☐ Yes, indicate in item 32 below. ☐ No
32. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other: *Name of other insurance:* _____ *Policy number:* _____
☐ 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)*

35. Name of family member *(last, first, middle initial)*
36. Social Security number
37. Date of birth *(mm/dd/yyyy)*
38. Sex ☐ M ☐ F
39. Relationship code
40. Address *(if different from enrollee)*
41. If you are covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
42. Medicare Claim Number
43. Are you covered by insurance other than Medicare? ☐ Yes, indicate in item 44 below. ☐ No
44. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other: *Name of other insurance:* _____ *Policy number:* _____
☐ 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)*
46. Preferred telephone number *(if home address is different from enrollee's)*

(continued on the reverse)

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)*

☐ 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

☐ 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)*

☐ 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)* __ / __ / ____
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)*
3. Personnel telephone number ( )
4. Name and address of agency or retirement system
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 ( )