



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 <i>(last, first, middle initial)</i> <b>Employee-Name</b>	2. Social Security number <b>Employee-SSN</b>	3. Date of birth <i>(mm/dd/yyyy)</i> <b>Birth-Date</b>	4. Sex <b>En</b> M <b>En</b> F	5. Are you married? <b>Mk</b> Yes <b>Mk</b> No
6. Home mailing address <i>(including ZIP Code)</i> <b>Employee-Address1</b>		7. If you are covered by Medicare, check all that apply. <b>En</b> A <b>En</b> B <b>En</b> D	8. Medicare Claim Number <b>Employee-Medicare-ClaimNo</b>	
9. Are you covered by insurance other than Medicare? <b>En</b> Yes, indicate in item 10 below. <b>En</b> 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 <i>(last, first, middle initial)</i> <b>Member1-Name</b>	12. Social Security number <b>Member1-SSN</b>	13. Date of birth <i>(mm/dd/yyyy)</i> <b>Member1-Birth-Date</b>	14. Sex <b>Mk</b> M <b>Mk</b> F	15. Relationship code <b>Member1-Relationship</b>
16. Address <i>(if different from enrollee)</i> <b>Member1-Address1</b>		17. If you are covered by Medicare, check all that apply. <b>Mk</b> A <b>Mk</b> B <b>Mk</b> D	18. Medicare Claim Number <b>Member1-Medicare-ClaimNo</b>	
19. Are you covered by insurance other than Medicare? <b>Mk</b> Yes, indicate in item 20 below. <b>Mk</b> No				

20. Indicate the type(s) of other insurance:  
**Mk** TRICARE **Mk** Other: *Name of other insurance:* **Member1-Insurance-Name** *Policy number:* **Member1-Policy-No**  
**Mk** 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 <i>(if home address is different from enrollee's)</i> <b>Member1-Email</b>		22. Preferred telephone number <i>(if home address is different from enrollee's)</i> <b>Member1-Phone</b>		
23. Name of family member <i>(last, first, middle initial)</i> <b>Member2-Name</b>	24. Social Security number <b>Member2-SSN</b>	25. Date of birth <i>(mm/dd/yyyy)</i> <b>Member2-Birth-Date</b>	26. Sex <b>Mk</b> M <b>Mk</b> F	27. Relationship code <b>Member2-Relationship</b>
28. Address <i>(if different from enrollee)</i> <b>Member2-Address1</b>		29. If you are covered by Medicare, check all that apply. <b>Mk</b> A <b>Mk</b> B <b>Mk</b> D	30. Medicare Claim Number <b>Member2-Medicare-ClaimNo</b>	
31. Are you covered by insurance other than Medicare? <b>Mk</b> Yes, indicate in item 32 below. <b>Mk</b> No				

32. Indicate the type(s) of other insurance:  
**Mk** TRICARE **Mk** Other: *Name of other insurance:* **Member2-Insurance-Name** *Policy number:* **Member2-Policy-No**  
**Mk** 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 <i>(if home address is different from enrollee's)</i> <b>Member2-Email</b>		34. Preferred telephone number <i>(if home address is different from enrollee's)</i> <b>Member2-Phone</b>		
35. Name of family member <i>(last, first, middle initial)</i> <b>Member3-Name</b>	36. Social Security number <b>Member3-SSN</b>	37. Date of birth <i>(mm/dd/yyyy)</i> <b>Member3-Birth-Date</b>	38. Sex <b>Mk</b> M <b>Mk</b> F	39. Relationship code <b>Member3-Relationship</b>
40. Address <i>(if different from enrollee)</i> <b>Member3-Address1</b>		41. If you are covered by Medicare, check all that apply. <b>Mk</b> A <b>Mk</b> B <b>Mk</b> D	42. Medicare Claim Number <b>Member3-Medicare-ClaimNo</b>	
43. Are you covered by insurance other than Medicare? <b>Mk</b> Yes, indicate in item 44 below. <b>Mk</b> No				

44. Indicate the type(s) of other insurance:  
**Mk** TRICARE **Mk** Other: *Name of other insurance:* **Member3-Insurance-Name** *Policy number:* **Member3-Policy-No**  
**Mk** 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 <i>(if home address is different from enrollee's)</i> <b>Member3-Email</b>		46. Preferred telephone number <i>(if home address is different from enrollee's)</i> <b>Member3-Phone</b>		
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<b>Part B - FEHB Plan You Are Currently Enrolled In (if applicable)</b>		<b>Part C - FEHB Plan You Are Enrolling In or Changing To</b>	
1. Plan name	2. Enrollment code	1. Plan name	2. Enrollment code
<b>Present-Plan-Name</b>	<b>Present-Enrollment-Code</b>	<b>New-Plan-Name</b>	<b>New-Plan-Code</b>
<b>Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2)</b>		<b>Part E - Election NOT to Enroll (Employees Only)</b>	
1. Event code	2. Date of event	<input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i><b>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</b></i>	
<b>Event-Code</b>	<b>Event-Date</b>		
<b>Part F - Cancellation of FEHB</b>		<b>Part G - Suspension of FEHB (Annuitants/Former Spouses Only)</b>	
<input type="checkbox"/> I CANCEL my enrollment. <i><b>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</b></i>		<input type="checkbox"/> I SUSPEND my enrollment. <i><b>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</b></i>	
<b>Part H - Signature</b>			
<b>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.)</b>			
1. Your signature (do not print)		2. Date (mm/dd/yyyy)	
<b>Employee-Signature</b>		<b>Signature-Date</b>	
3. Email address		4. Preferred telephone number	
<b>Employee-Email</b>		<b>Daytime-Telephone</b>	
<b>Part I -To be completed by agency or retirement system</b>			
<b>REMARKS</b>			
Remarks			

  

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