



## **Health Benefits Election Form**

Part A - Enrollee and Family Member Information (for	additional family member	rs us	se a se	eparate	sheet	and attach)	)						
Enrollee name (last, first, middle initial)	2. Social Security Number						4. S	ex		5. 4	Are you married?		
							٠,		F		Vac Na		
6. Home mailing address (including ZIP Code)		7.	If you	ı are cov	ered by	Medicare,		M ledicare			Yes No		
o. From maning address (including 211 Code)			check	all that	apply.		0. 14	reareare	Bene	i i c i ci i	racitimer		
			Α	В		D							
		9.	Are y	ou cove	red by 1	nsurance oth	er tha	ın Medi	care?				
			Yes,	indicate	in item	n 10 below.			No				
10. Indicate the type(s) of other insurance:													
TRICARE Other Name of other insurance:							-	Numbe					
FEHB An FEHB Self Plus One enrollment covers the enrol enrollee and all eligible family members. No person													
			12. Preferred telephone number										
					•								
13. Name of family member ( <i>last, first, middle initial</i> )	14. Social Security Number	15	Date	of hirth	(mm/da	d/www)	16	Sex		17	Relationship code		
13. Table of family memori (tast, just, maare sumar)	11. Social Security Trainioci	13.	Dute	or on th	(mm ccc	~ 33337	10.	Den _	-	17.	reductionship code		
		10	¥0.1	0 11				M	F				
18. Address (if different from enrollee)		19.	by M	is family Iedicare,	membe check	er is covered all that apply	. 20.	Medica	are Be	nefici	ary Identifier		
			A	В		D							
		21.	Is th	is family	membe	er covered by	insu	rance ot	her tha	an Me	dicare?		
		П	Yes,	indicate	in item	n 22 below.			No				
22. Indicate the type(s) of other insurance:													
TRICARE Other Name of other insurance:						F	Policy	Numbe	r:				
FEHB An FEHB Self Plus One enrollment covers the enrol enrollee and all eligible family members. No person													
23. Email address (if applicable, enter email address of your spou	use or adult child)	24.	Prefe	rred tele	phone r	number (if ap	plica	ble, ente	r pref	erred	phone number of		
	,		your	spouse d	or adult	child)					. ,		
25. Name of family member ( <i>last, first, middle initial</i> )	26. Social Security Number	27.	Date	of birth	(mm/da	d/vvvv)	28.	Sex		29.	Relationship code		
(,					,	55557			7		1		
20 411 (6.1%		2.1	10.1	· C ·1			22	M	F	o	×1 .: 0		
30. Address (if different from enrollee)		31.	by M	s ramity ledicare,	check	all that apply	. 32.	Medica	are Be	nefici	ary Identifier		
			A	В		D							
				is family	membe	er covered by	insu	rance ot	her tha	an Me	dicare?		
			Yes,	indicate	in item	a 34 below.			No				
34. Indicate the type(s) of other insurance:	I												
TRICARE Other Name of other insurance: Policy Number:													
FEHB An FEHB Self Plus One enrollment covers the enrol enrollee and all eligible family members. No person													
35. Email address (if applicable, enter email address of your spouse or adult child)										1 0	phone number of		
			your spouse or adult child)										
37. Name of family member ( <i>last, first, middle initial</i> )	38. Social Security Number	39	Date	of hirth	(mm/da	d/www.)	40	Sex		41	Relationship code		
37. Ivame of family member (tast, jirst, madic initial)	36. Social Security Number	37.	Date	or onth	(mm/ac	wyyyy	40.		_	71.	relationship code		
								M	F				
42. Address (if different from enrollee)		43.	by M	s family Iedicare,	membe check	er is covered all that apply	. 44.	Medica	are Be	nefici	ary Identifier		
			A	В		D							
			Is th	is family	membe	er covered by	insu	rance ot	her tha	an Me	dicare?		
			Yes.	indicate	in item	n 46 below.			No				
46. Indicate the type(s) of other insurance						0 001011.			1.5				
TRICARE Other Name of other insurance:						L	Police	Numbo	ŗ.				
TRICARE Other Name of other insurance:  FEHB An FEHB Self Plus One enrollment covers the enrollee and one eligible family mem					Policy Number: Policy Number: nber designated by the enrollee. An FEHB Self and Family enrollment covers the								
enrollee and all eligible family members. No person may be covered under more t				EHB eni	rollmen	t. See instruc	tions	for item	10 or	i page	1.		
47. Email address (if applicable, enter email address of your spouse or adult child)				rred tele spouse o			plica	ble, ente	r pref	erred	phone number of		
			,	1									

Enrollee name:		Date of birth:								
Part B - FEHB Plan You Are Currently Enrolled In (if applicable)		Part C - FEHB Plan You Are Enrolling In or Changing To								
1. Plan name	2. Enrollment code	1. Plan name 2. Enrollment code								
Part D - Event That Permits You To	o Enroll, Change, or Cancel (see page 6)	Part E - Election NOT to Enroll (Employees Only)								
1. Event code	2. Date of event	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		Part G - Suspension of FEHB (Annuitants/Former Spouses Only)								
I CANCEL my enrollment.  My signature in Part H certifies information on page 3 regarding	that I have read and understand the g cancellation of enrollment.	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 state \$10,000 or imprisonment of not more tha	11 0 1	ntation relative thereto is a violation of the law punishable by a fine of not more than								
1. Your signature (do not print)		2. Date (mm/dd/yyyy)								
Part I -To be completed by agency	or retirement system									
REMARKS										
1. Date received (mm/dd/yyyy)	2. Effective date of action (n	3. Personnel telephone number								
4. Name and address of agency or retirem	nent system	5. Authorizing official (please print)								
		6. Signature of authorized agency official								
7. Payroll office number	8. Payroll office contact (pla	9. Payroll telephone number								