

PostalEASE FEHB Worksheet

This worksheet will help you prepare to call *PostalEASE*, or use *PostalEASE* on the Postal Service Intranet (from the Blue page), the Internet (<https://liteblue.usps.gov>) or on an Employee Self-Service Kiosk (now available in some facilities). You may also prepare this worksheet and contact the Human Resources Shared Service Center (HRSSC) if you cannot enroll or make a change because *PostalEASE* does not accept the required documentation.

Note: If you have any trouble using *PostalEASE*, or if you are unable to use the telephone because you are deaf or hard of hearing, or you cannot use the telephone, Internet, or Employee Self-Service Kiosk for medical reasons, you may contact the HRSSC for assistance. **If you contact the HRSSC, be sure to complete this worksheet first.**

Part 1 – Employee Information

Your Name (Last, First, Middle Initial)	Employee ID
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Type Of Action You Are Requesting

Open Season: New Enrollment Change Current Enrollment Cancel Enrollment

New Hire: New Enrollment Waive Enrollment

Special Enrollment (if you are notified that your current plan is being discontinued or your service area is reduced):

Change Current Enrollment Cancel Enrollment Other QLE: _____

New Plan Enrollment Code _____ **New Plan Name** _____

Old Plan Enrollment Code (if you are changing plans or cancelling your current plan) _____

Please note:

Changes due to a qualifying life event (QLE) cannot be made via *PostalEASE*.

If you wish to make any change that is not listed under “Type of Action You Are Requesting” above, you must contact the HRSSC. You will need to present documentation showing that your election is due to a QLE and that you are contacting the HRSSC within the required time frame.

For more information on qualifying life events, please refer to the RI 70-2, *Guide to Benefits*, which is mailed to you each FEHB open season.

Your Other Group Insurance (Not used for waiving enrollment as a new employee)	
<p>Do you have any group health insurance coverage other than under the FEHB plan in which you are now enrolling or already enrolled?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Identify Type of Other Insurance Coverage</p> <p><input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B</p> <p><input type="checkbox"/> Tricare or Champus Policy No. (if known) _____</p> <p>Other Group Insurance Name _____</p> <p>Policy No. (if known) _____</p>

<p>Your Gender: <input type="checkbox"/> Male</p> <p style="text-align: center;"><input type="checkbox"/> Female</p>	<p>Married: <input type="checkbox"/> Yes</p> <p style="text-align: center;"><input type="checkbox"/> No</p>	<p>Daytime Telephone Number (with area code)</p>
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Part 2 – Dependent Information (for Self and Family coverage only)

A complete mailing address (if different from yours) and other insurance information (if any) must be provided for each covered dependent. If you are adding or updating information for a dependent who does not reside with you, you will need to use the PostalEASE Employee Web on the Postal Service Intranet (Blue page), the Internet (<https://liteblue.usps.gov>) or at an Employee Self-Service Kiosk (available in some facilities) or contact the HRSSC to make or change your FEHB enrollment.

Please check here if all dependents reside with you.

Family Member Names <small>(Last, First, Middle Initial)</small>	Address (Street, City, State, Zip) <small>(If different from yours)</small>	Gender	Date of Birth	Rel. Code*	SSN <small>(Optional)</small>	Other Group Insurance Co. <small>Name & Policy No.</small>

* Relationship Codes: 01 = Spouse
 02 = Spouse from a common law marriage (requires certification to be filed with the HRSSC)
 19 = Child
 09 = Adopted child
 10 = Foster child (requires certification to be filed with the HRSSC)
 17 = Stepson or stepdaughter
 99 = Unmarried child over age 22 incapable of self-support (requires certification to be filed with the HRSSC)

Employee Signature _____ Date _____ Record the Confirmation Number You Receive From PostalEASE Here _____

For HRSSC Use Only

REMARKS: Specific information on type of qualifying life event, reason for correction, type of certification, supporting documentation, reason for verification, etc., should be provided here.

Employing Office _____ Date Received in Personnel Office _____

Address _____

Contact Name _____ Date of QLE/Birth _____

File copy in OPF for any FEHB transaction processed by HRSSC and ASC

PRIVACY ACT STATEMENT: The collection of this information is authorized by 39 USC 401, 1001, 1003, 1005; 5 USC 8339; 42 USC 2000e-16, and Executive Orders 11478 and 11590. This information will be used to process your enrollment in the Federal Employees Health Benefit system and to manage your claim under that plan. As a routine use, the information may be disclosed to an appropriate government agency, domestic or foreign, for law enforcement purposes; where pertinent, in a legal proceeding to which the USPS is a party or has an interest; to a government agency in order to obtain information relevant to a USPS decision concerning employment, security clearances, contracts, licenses, grants, permits or other benefits; to a government agency upon its request when relevant to its decision concerning employment, security clearances, security or suitability investigations, contracts, licenses, grants or other benefits; to a congressional office at your request; to an expert, consultant, or other person under contract with the USPS to fulfill an agency function; to the Federal Records Center for storage; to the Office of Management and Budget for review of private relief legislation; to an independent certified public accountant during an official audit of USPS finances; to an investigator, administrative judge or complaints examiner appointed by the Equal Employment Opportunity Commission for investigation of a formal EEO complaint under 29 CFR 1614; to the Merit Systems Protection Board or Office of Special Counsel for proceedings or investigations involving personnel practices and other matters within their jurisdiction; to a labor organization as required by the National Labor Relations Act; to agencies having taxing authority for taxing purposes; to financial organizations receiving allotments; to State Employment Security Agencies to process unemployment compensation claims; to a Federal or state agency providing parent locator service or to other authorized persons as defined by Pub. L. 93-647; to the National Association of Postal Supervisors that relates to postal supervisors; to a prospective employer for consideration of employment; to management for compilation of a local seniority list for posting; to the EEOC for enforcement of Federal EEO regulations; to the appropriate finance center as required under the provisions of the Dual Compensation Act; to the Office of Personnel Management, Social Security Administration, Veterans Administration, Office of Workers' Compensation Programs; health insurance carriers, or plans, or other program management agencies or retirement systems for use in determining a claim for benefits; and to OPM for its active employee/annuitant data systems used to analyze Federal retirement and insurance costs. Providing the information is voluntary; however, if this information is not provided, we may not be able to process your enrollment. We also request that you provide your social security number so that it may be used as your individual identifier in the Federal Employee Health Benefits system. Executive order 9397 dated November 22, 1943, allows Federal Agencies to use the social security number as an individual identifier to distinguish between people with the same or similar names. Computer Matching: Limited information may be disclosed to a Federal, state, or local government administering benefits or other programs pursuant to statute for purpose of conducting computer matching programs under the Act. These programs include, but are not limited to, matches performed to verify an individual's initial or continuing eligibility for, indebtedness to, or compliance with requirements of a benefit program.