FEHB
Federal Employees Health Benefits Program

Health Benefits Election Form

Form Approved:
OMB No. 3206-0160

Uses for Standard Form (SF) 2809

Use this form to:

- Enroll or reenroll in the FEHB Program; or
- Elect not to enroll in the FEHB Program *(employees only)*; or
- Change your FEHB enrollment; or
- Cancel your FEHB enrollment; or
- Suspend your FEHB enrollment *(annuitants or former spouses only)*.

Who May Use SF 2809

1. Employees eligible to enroll in or currently enrolled in the FEHB Program, including temporary employees eligible under 5 U.S.C. 8906a. ***Employees automatically participate in premium conversion unless they waive it, see page 7.***
2. Annuitants (other than Civil Service Retirement System [CSRS] and Federal Employees Retirement System [FERS] annuitants) eligible to enroll in or currently enrolled in the FEHB Program, including individuals receiving monthly compensation from the Office of Workers' Compensation Programs (OWCP).

   Note: *Civil Service Retirement System (CSRS) and Federal Employees Retirement System (FERS) annuitants and former spouses and children of CSRS/FERS annuitants --* ***Do not use this form.*** *Instead, call the Retirement Information Office toll-free at 1-888-767-6738. Customers within the local calling distance to Washington, DC, should call 202-606-0500.*
3. Former spouses eligible to enroll in or currently enrolled in the FEHB Program under the Spouse Equity law or similar statutes.
4. Individuals eligible for Temporary Continuation of Coverage (TCC) under the FEHB Program, including:
   - Former employees (who separated from service);
   - Children who lose FEHB coverage; and
   - Former spouses who are not eligible for FEHB under item 3 above.

Instructions for Completing SF 2809

Type or Print Firmly. We have not provided instructions for those items that have an explanation on the form.

Part A — Enrollee and Family Member Information.
You must complete this part.

Item 2. See the Privacy Act and Public Burden Statements on page 5.

Item 5. If you are separated but not divorced, you are still married.

Item 7. If you have Medicare, show which Parts you have. If you complete this form after November 15, 2005, also indicate whether you have prescription drug coverage under the Medicare Part D program.

Item 8. TRICARE is a health care program for active duty and retired members of the uniformed services, their families, and survivors. This includes TRICARE for Life for members 65 and over.

Item 9. If you have other group insurance (private, state, Medicaid, CHAMPVA), check the box.

Item 10. Write the name of any other insurance you have.

Complete information for family members only if your enrollment is for Self and Family. (If you need extra space for additional family members, list them on a separate sheet and attach.)

Item 13. Please provide Social Security Numbers for your dependents if available. If not available, leave blank; benefits will not be withheld. (See Privacy Act Statement on page 5.)

Item 16. Provide the code which indicates the relationship of each eligible family member to you.

Code	Family Relationship
01	Spouse
19	Unmarried dependent child under age 22
09	Adopted Child
17	Stepchild
10	Foster Child
99	Unmarried disabled child over age 22 incapable of self support because of a physical or mental disability that began before age 22.

Item 18. If a family member has Medicare, show which Parts he/she has on the line with his/her name. If you complete this form after November 15, 2005, also indicate whether you have prescription drug coverage under the Medicare Part D program.

Item 19. If a family member has TRICARE, see item 8. Check the box.

Item 20. If a family member has other group insurance (private, state, Medicaid), check the box.

Item 21. Give the name of any other insurance this family member has.

Family Members Eligible for Coverage

Unless you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment include your spouse and your unmarried dependent children under age 22. Eligible children include your legitimate or adopted children; and recognized children born out of wedlock, stepchildren or foster children, if they live with you in a regular parent-child relationship. A recognized child born out of wedlock also may be included if a judicial determination of support has been obtained or you show that you provide regular and substantial support for the child.

Other relatives (for example, your parents) are ***not*** eligible for coverage even if they live with you and are dependent upon you.

- If you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment are the unmarried dependent natural or adopted children under age 22 of both you and your former or deceased spouse.
- Children whose marriage ends before they reach age 22 become eligible for coverage under your Self and Family enrollment from the date the marriage ends until they reach age 22.

In some cases, an unmarried, disabled child who is 22 years old or older is eligible for coverage under your Self and Family enrollment if you provide adequate medical certification of a mental or physical handicap that existed before his or her 22nd birthday and renders the child incapable of self-support.

Note: *Your employing office can give you additional details about family member eligibility including any certification or documentation that may be required for coverage. "Employing office" means the office of an agency or retirement system that is responsible for health benefits actions for an employee, annuitant, former spouse eligible for coverage under the Spouse Equity provisions, or individual eligible for TCC.*

Part B — Present Plan.

You must complete this part if you are changing, cancelling, or suspending your enrollment.

Item 1. Enter the name of the plan you are enrolled in from the front cover of the plan brochure.

Item 2. Enter your present enrollment code.

Part C — New Plan.

Complete this part to enroll or change your enrollment in the FEHB Program.

Items 1 and 2. Enter the plan name and enrollment code from the front cover of the brochure of the plan you want to be enrolled in. The enrollment code shows the plan and option you are electing and whether you are enrolling for Self Only or Self and Family.

To enroll in a Health Maintenance Organization (HMO), you must live (or in some cases work) in a geographic area specified by the carrier.

To enroll in an employee organization plan, you must be or become a member of the plan's sponsoring organization, as specified by the carrier.

Your signature in Part H authorizes deductions from your salary, annuity, or compensation to cover your cost of the enrollment you elect in this item, unless you are required to make direct payments to the employing office.

Part D — Event Code.

Item 1. Enter the event code that permits you to enroll, change, or cancel based on a qualifying life event (QLE) from the Table of Permissible Changes in Enrollment that applies to you.

Explanation of Table of Permissible Changes in Enrollment

The tables on pages 7 through 14 illustrate when: an employee who participates in premium conversion; annuitant; former spouse; person eligible for TCC; or employee who waived participation in premium conversion may enroll or change enrollment. The tables show those permissible events that are found in the regulations at 5 CFR Parts 890 and 892.

The tables have been organized by enrollee category. Each category is designated by a number, which identifies the enrollee group, as follows:

1. Employees who participate in premium conversion
2. Annuitants (other than CSRS/FERS annuitants), including individuals receiving monthly compensation from the Office of Workers' Compensation Programs
3. Former spouses eligible for coverage under the Spouse Equity provision of FEHB law
4. TCC enrollees
5. Employees who waived participation in premium conversion

Following each number is a letter, which identifies a specific permissible event; for example, the event code "1A" refers to the initial opportunity to enroll for an employee who elected to participate in premium conversion.

Item 2. Enter the date of the permissible event using numbers to show month, day, and complete year; e.g., 06/30/2004. If you are electing to enroll, enter the date you became eligible to enroll (for example, the date your appointment began). If you are making an open season enrollment or change, enter the date on which the open season begins.

Part E — Election NOT to Enroll.

Place an "X" in the box provided only if you are an employee and you do NOT wish to enroll in the FEHB Program. ***Be sure to read the information below in the paragraph titled*** *Employees Who Elect Not to Enroll or Who Cancel Their Enrollment*.

Part F — Cancellation.

Place an "X" in the box provided only if you wish to cancel your FEHB enrollment. Also enter your present enrollment code in ***Part B***. ***Be sure to read the information below in the paragraph titled*** *Employees Who Elect Not to Enroll or Who Cancel Their Enrollment*.

Note For Parts E and F. *If you are not enrolling or cancelling your enrollment because you are covered as a spouse or child under another FEHB plan, please write the enrollee's name, social security number, and FEHB enrollment code in REMARKS.*

Cancellation of Enrollment

Employees participating in premium conversion may cancel their FEHB enrollment only during the open season or when they experience a qualifying life event. Employees who waived participation in premium conversion, annuitants, former spouses, and individuals enrolled under TCC may cancel their enrollment at any time. However, if you cancel, neither you nor any family member covered by your enrollment are entitled to a 31-day temporary extension of coverage, or to convert to an individual, nongroup policy. Moreover, family members who lose coverage because of your cancellation are not eligible for TCC. Be sure to read the additional information below about cancelling your enrollment.

Employees Who Elect Not to Enroll or Who Cancel Their Enrollment

To be eligible for an FEHB enrollment after you retire, you must retire:

- Under a retirement system for Federal civilian employees, and
- On an immediate annuity.

In addition, you must be currently enrolled in a plan under the FEHB Program and must have been enrolled (or covered as a family member) in a plan under the Program for:

- The 5 years of service immediately before retirement (i.e., commencing date of annuity entitlement), or
- If fewer than 5 years, all service since your first opportunity to enroll. (Generally, your first opportunity to enroll is within 60 days after your first appointment [in your Federal career] to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

If you do not enroll at your first opportunity or if you cancel your enrollment, you may later enroll or reenroll only under the circumstances explained in the table beginning on page 7. Some employees delay their enrollment or reenrollment until they are nearing 5 years before retirement in order to qualify for FEHB coverage as a retiree; however, there is always the risk that they will retire earlier than expected and not be able to meet the 5-year requirement for continuing FEHB coverage into retirement. Please understand that when you elect not to enroll or cancel your enrollment ***you are voluntarily accepting this risk***. An alternative would be to enroll in or change to a lower cost plan so that you meet the requirements for continuation of your FEHB enrollment after retirement.

Note for temporary [under 5 U.S.C. 8906a] employees eligible for FEHB without a Government contribution: *Your decision not to enroll or to cancel your enrollment will* ***not*** *affect your future eligibility to continue FEHB enrollment after retirement.*

Annuitants Who Cancel Their Enrollment

CSRS and FERS annuitants and their dependents should not use this form but call 1-888-767-6738, or 202-606-0500 within the Washington, D.C. area.

Generally, you cannot reenroll as an annuitant unless you are continuously covered as a family member under another person's enrollment in the FEHB Program during the period between your cancellation and reenrollment. Your employing office or retirement system can advise you on events that allow eligible annuitants to reenroll. If you cancel your enrollment because you are covered under another FEHB enrollment, you can reenroll from 31 days before through 60 days after you lose that coverage under the other enrollment.

If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.

Former Spouses (Spouse Equity) Who Cancel Their Enrollment

Generally, if you cancel your enrollment in the FEHB Program, you cannot reenroll as a former spouse. However, if you stop the enrollment because you acquire other FEHB coverage as a new spouse or employee, your right to FEHB coverage under the Spouse Equity provisions continues. You may reenroll as a former spouse from 31 days before through 60 days after you lose coverage under the other FEHB enrollment.

If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.

Temporary Continuation of Coverage Enrollees Who Cancel Their Enrollment

If you cancel your TCC enrollment, you cannot reenroll. Your family members who lose coverage because of your cancellation cannot enroll for TCC in their own right nor can they convert to a nongroup policy. However, family members who are Federal employees or annuitants may enroll in the FEHB Program when you cancel your coverage if they are eligible for FEHB coverage in their own right.

Note 1: *If you become covered by a regular enrollment in the FEHB Program, either in your own right or under the enrollment of someone else, your TCC enrollment is suspended. You will need to send documentation of the new enrollment to the employing office maintaining your TCC enrollment so that they can stop the TCC enrollment. If your new FEHB coverage stops before the TCC enrollment would have expired, the TCC enrollment can be reinstated for the remainder of the original eligibility period (18 months for separated employees or 36 months for dependents who lose coverage).*

Note 2: *Former spouses (Spouse Equity) and* TCC *enrollees who fail to pay their premiums within specified timeframes are considered to have voluntarily cancelled their enrollment.*

Part G — Suspension.

CSRS and FERS annuitants and their dependents should not use this form but call 1-888-767-6738, or 202-606-0500 within the Washington, D.C. area.

Place an "X" in the box only if you are an annuitant or former spouse and wish to suspend your FEHB enrollment. Also enter your present enrollment code in Part B.

You may suspend your FEHB enrollment because you are enrolling in one of the following programs:

- A Medicare HMO or Medicare Advantage plan,
- Medicaid or similar State-sponsored program of medical assistance for the needy,
- TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), or
- CHAMPVA

You can reenroll in the FEHB Program if your other coverage ends. If your coverage ends ***involuntarily***, you can reenroll 31 days before through 60 days after loss of coverage. If your coverage ends ***voluntarily*** because you disenroll, you can reenroll during the next open season.

You must submit documentation of eligibility for coverage under the non-FEHB Program to the office that maintains your enrollment. That office must enter in REMARKS the reason for your suspension.

Part H — Signature.

Your agency, retirement system, or office maintaining your enrollment cannot process your request unless you complete this part.

If you are registering for someone else under a written authorization from him or her to do so, sign your name in Part H and attach the written authorization.

If you are registering for a former spouse eligible for coverage under the Spouse Equity provisions or for an individual eligible for TCC as his or her court-appointed guardian, sign your name in Part H and attach evidence of your court-appointed guardianship.

Part I - Agency or Retirement System Information and Remarks.

Leave this section blank as it is for agency or retirement system use only.

Guides to Federal Employees Health Benefits Plans (FEHB Guides) and Plan Brochures

FEHB Guides contain plan and rate information. Be sure you have the correct guide for your enrollment category since more than one guide is used.

FEHB Plan brochures contain detailed information about plan benefits and the contractual description of coverage.

Where to Obtain FEHB Guides and Brochures

FEHB Guides and plan brochures may be available from your employing office or the office that maintains your enrollment.

Your plan will send you its brochure before the beginning of each contract year. You may also get copies of plan brochures by contacting the plans directly at the telephone numbers shown in the FEHB Guide. The FEHB Guide also shows which plans have their own website.

The FEHB Guide, plan brochures, and other information, including links to plan websites, are available on the FEHB website at ***http://www.opm.gov/insure/health***.

Electronic Enrollments

Many agencies use automated systems that allow their employees to make changes using a touch-tone telephone, or a computer instead of a form. This may be Employee Express or some other automated system. If you are not sure whether the electronic enrollment option is available to you, contact your employing office.

Dual Enrollment

Normally, you are not eligible to enroll if you are covered as a family member under someone else's enrollment in the FEHB Program. However, such dual enrollments may be permitted under certain circumstances in order to:

- Protect the interests of children who otherwise would lose coverage as family members, or
- Enable an employee who is under age 22 and covered under a parent's enrollment and becomes the parent of a child to enroll for Self and Family coverage.

No person (enrollee or family member) is entitled to receive benefits under more than one enrollment in the Program. Each enrollee must notify his or her plan of the names of the persons to be covered under his or her enrollment who are not covered under the other enrollment.

Temporary Continuation of Coverage (TCC)

The employing office must notify a former employee of his or her eligibility for TCC. The enrollee, child, former spouse, or their representative must notify the employing office when a child or former spouse becomes eligible.

- For the eligible child of an enrollee, the enrollee must notify the employing office within ***60 days*** after the qualifying event occurs; e.g., child reaches age 22.
- For the eligible former spouse of an enrollee, the enrollee or the former spouse must notify the employing office within ***60 days*** after the former spouse's change in status; e.g., the date of the divorce.

An individual eligible for TCC who wants to continue FEHB coverage may choose any plan for which he or she is eligible, option, and type of enrollment. The time limit for a former employee, child, or former spouse to enroll with the employing office is within ***60 days*** after the qualifying life event, or receiving notice of eligibility, whichever is later.

Note:

- *If someone other than the enrollee notifies the employing office of the child's eligibility for TCC within the specified time period, the child's opportunity to enroll ends 60 days after the qualifying event.*
- *If someone other than the enrollee or the former spouse notifies the employing office of the former spouse's eligibility for continued coverage within the specified time period, the former spouse's opportunity to enroll ends 60 days after the change in status.*

Effective Dates

Except for open season, most enrollments and changes of enrollment are effective on the first day of the pay period after the employing office receives this form and that follows a pay period during any part of which the employee is in pay status. Your employing office can give you the specific date on which your enrollment or enrollment change will take effect.

Note 1: *If you are changing your enrollment from Self and Family to Self Only so that your spouse can enroll for Self Only, you should coordinate the effective date of your spouse's enrollment with the effective date of your enrollment change to avoid a gap in your spouse's coverage.*

Note 2: *If you are cancelling your enrollment and intend to be covered under someone else's enrollment at the time you cancel, you should coordinate the effective date of your cancellation with the effective date of your new coverage to avoid a gap in your coverage.*

Privacy Act Statement

The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program (FEHB) under Chapter 89, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB Program. Executive Order 9397 (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. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

Agencies other than the OPM may have further routine uses for disclosure of information from the records system in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

Public Burden Statement

We think this form takes an average of 30 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, OPM Forms Officer, (3206-0160), Washington, D.C. 20415-7900. The OMB number, 3206-0160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Federal Employees Receiving Premium Conversion Tax Benefits
Table of Permissible Changes in FEHB Enrollment and Premium Conversion Election

Premium Conversion allows employees who are eligible for FEHB the opportunity to pay for their share of FEHB premiums with pre-tax dollars. Premium conversion plans are governed by Section 125 of the Internal Revenue Code, and IRS rules govern when a participant may change his or her election outside of the annual open season. **All employees who enroll in the FEHB Program automatically receive premium conversion tax benefits,** unless they waive participation**.** When an employee experiences a qualifying life event (QLE) as described below, changes to the employee's FEHB coverage **(including change to self only and cancellation)** and premium conversion election may be permitted, so long as they are **because of and consistent with** the QLEs. For more information about premium conversion, please visit *www.opm.gov/insure/health*.

Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election		***FEHB Enrollment Change that May Be Permitted***				***Premimum Conversion Election Change that May Be Permitted***		***Time Limits in which Change May Be Permitted***
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*[1]	*Participate*	*Waive*	*When You Must File Health Benefits Election Form With Your Employing Office*
1	**Employee electing to receive or receiving premium conversion tax benefits**							
1A	Initial opportunity to enroll, for example: • New employee • Change from excluded position • Temporary employee who completes 1 year of service and is eligible to enroll under 5 USC 8906a	Yes	N/A	N/A	N/A	***Automatic Unless Waived***	Yes	Within 60 days after becoming eligible
1B	Open Season	Yes	Yes	Yes	Yes	Yes	Yes	As announced by OPM
1C	Change in family status that results in increase or decrease in number of eligible family members, for example: • Marriage, divorce, annulment, legal separation • Birth, adoption, acquiring foster child or stepchild, issuance of court order requiring employee to provide coverage for child • Last dependent child loses coverage, for example, child reaches age 22 or marries, stepchild moves out of employee's home, disabled child becomes capable of self-support, child acquires other coverage by court order • Death of spouse or dependent	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after change in family status
		Employees may enroll or change beginning 31 days before the event.						
1D	Any change in employee's employment status that could result in entitlement to coverage, for example: • Reemployment after a break in service of more than 3 days • Return to pay status from nonpay status, or return to receiving pay sufficient to cover premium withholdings, if coverage terminated *(If coverage did not terminate, see 1G.)*	Yes	N/A	N/A	N/A	***Automatic Unless Waived***	Yes	Within 60 days after employment status change
1E	Any change in employee's employment status that could affect cost of insurance, including: • Change from temporary appointment with eligibility for coverage under 5 USC 8906a to appointment that permits receipt of government contribution • Change from full time to part-time career or the reverse	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after employment status change
1F	Employee restored to civilian position after serving in uniformed services.[2]	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after return to civilian position

Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election		***FEHB Enrollment Change that May Be Permitted***				***Premimum Conversion Election Change that May Be Permitted***		***Time Limits in which Change May Be Permitted***
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*	*Participate*	*Waive*	*When You Must File Health Benefits Election Form With Your Employing Office*
1G	Employee, spouse or dependent: • Begins nonpay status or insufficient pay[3] or • Ends nonpay status or insufficient pay if coverage continued • *(If employee's coverage terminated, see 1D.)* • *(If spouse's or dependent's coverage terminated, see 1M.)*	No	No	No	Yes	Yes	Yes	Within 60 days after employment status change
1H	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Yes	Yes	Yes	Within 60 days after receiving notice from employing office
1I	Employee (or covered family member) enrolled in FEHB health maintenance organization (HMO) moves or becomes employed outside the geographic area from which the FEHB carrier accepts enrollments or, if already outside the area, moves further from this area.[4]	N/A	Yes	Yes	N/A *(see 1M)*	No *(see 1M)*	No *(see 1M)*	Upon notifying employing office of move
1J	Transfer from post of duty within a State of the United States or the District of Columbia to post of duty outside a State of the United States or District of Columbia, or reverse.	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after arriving at new post
		Employees may enroll or change beginning 31 days before leaving the old post of duty.						
1K	Separation from Federal employment when the employee or employee's spouse is pregnant.	Yes	Yes	Yes	N/A	N/A	N/A	During employee's final pay period
1L	Employee becomes entitled to Medicare and wants to change to another plan or option. [5]	No	No	Yes *(Changes may be made only once.)*	N/A *(see 1M)*	N/A *(see 1M)*	N/A *(see 1M)*	Any time beginning on the 30th day before becoming eligible for Medicare
1M	Employee or eligible family member loses coverage under FEHB or another group insurance plan including the following: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment • Loss of coverage due to termination of membership in employee organization sponsoring the FEHB plan[6] • Loss of coverage under another federally-sponsored health benefits program, including: TRICARE, Medicare, Indian Health Service • Loss of coverage under Medicaid or similar State-sponsored program of medical assistance for the needy • Loss of coverage under a non-Federal health plan, including foreign, state or local government, private sector • Loss of coverage due to change in worksite or residence *(Employees in an FEHB HMO, also see 1I.)*	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after loss of coverage
		Employees may enroll or change beginning 31 days before the event.						
1N	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-Federally employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area to 180 days after arriving in the new commuting area
1O	Employee or eligible family member loses coverage due to discontinuance in whole or part of FEHB plan.[7]	Yes	Yes	Yes	Yes	Yes	Yes	During open season, unless OPM sets a different time

Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election		***FEHB Enrollment Change that May Be Permitted***				***Premimum Conversion Election Change that May Be Permitted***		***Time Limits in which Change May Be Permitted***
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*	*Participate*	*Waive*	*When You Must File Health Benefits Election Form With Your Employing Office*
1P	Enrolled employee or eligible family member gains coverage under FEHB or another group insurance plan, including the following: • Medicare (Employees who become eligible for Medicare and want to change plans or options, see 1L.) • TRICARE for Life, due to enrollment in Medicare. • TRICARE due to change in employment status, including: (1) entry into active military service, (2) retirement from reserve military service under Chapter 67, title 10. • Medicaid or similar State-sponsored program of Medical assistance for the needy • Health insurance acquired due to change of worksite or residence that affects eligibility for coverage • Health insurance acquired due to spouse's or dependent's change in employment status (includes state, local, or foreign government or private sector employment).[8]	No	No	No	Yes	Yes	Yes	Within 60 days after QLE
1Q	Change in spouse's or dependent's coverage options under a non-Federal health plan, for example: • Employer starts or stops offering a different type of coverage *(If no other coverage is available, also see 1M.)* • Change in cost of coverage • HMO adds a geographic service area that now makes spouse eligible to enroll in that HMO • HMO removes a geographic area that makes spouse ineligible for coverage under that HMO, but other plans or options are available*(If no other coverage is available, see 1M)*	No	No	No	Yes	Yes	Yes	Within 60 days after QLE

(If you are a United States Postal Service employee, these rules may be different. Consult your employing office or information provided by your agency.)

1. Employees may change to self only outside of open season only if ***the QLE caused*** the enrollee to be the last eligible family member under the FEHB enrollment. Employees may cancel enrollment outside of open season only if ***the QLE caused*** the enrollee and all eligible family members to acquire other health insurance coverage.

2. Employees who enter active military service are given the opportunity to terminate coverage. Termination for this reason does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement. Additional information on the FEHB coverage of employees who return from active military service will be forthcoming.

3. Employees who begin nonpay status or insufficient pay ***must*** be given an opportunity to elect to continue or terminate coverage. A termination differs from a cancellation as it allows conversion to nongroup coverage and does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement.

4. This code reflects the FEHB regulation that gives employees enrolled in an FEHB HMO who ***change from self only to self and family or from one plan or option to another*** a different timeframe than that allowed under 1M. For change to self-only, cancellation, or change in premium conversion status, see 1M.

5. This code reflects the FEHB regulation that gives employees enrolled in FEHB a one-time opportunity to change plans or options under a different timeframe than that allowed by 1P. For change to self only, cancellation, or change in premium conversion status, see 1P.

6. If employee's membership terminates (e.g., for failure to pay membership dues), the employee organization will notify the agency to ***terminate*** the enrollment.

7. Employee's failure to select another FEHB plan is deemed a cancellation for purposes of meeting the requirements for continuing coverage after retirement.

8. Under IRS rules, this includes start/stop of employment or nonpay status, strike or lockout, and change in worksite.

Tables of Permissible Changes in FEHB Enrollment for Individuals Who Are Not Participating in Premium Conversion

Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time

QLE's That Permit Enrollment or Change		***Change Permitted***			***Time Limits***
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
2	**Annuitant (Includes Compensationers)** ***Note for enrolled survivor annuitants:*** A change in family status based on additional family members can only occur if the additional eligible family members are family members of the deceased employee or annuitant.				
2A	Open Season	No	Yes	Yes	As announced by OPM.
2B	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after the event.
2C	Reenrollment of annuitant who cancelled FEHB enrollment to enroll in a Medicare-sponsored plan, Medicaid, or similar State-sponsored program and who later was ***involuntarily*** disenrolled from the Medicare-sponsored plan, Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment.
2D	Reenrollment of annuitant who cancelled FEHB enrollment to enroll in a Medicare-sponsored plan, Medicaid, or similar State-sponsored program and who later ***voluntarily*** disenrolls from the Medicare-sponsored plan, Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	During open season.
2E	Restoration of annuity or compensation (OWCP) payments; for example: • Disability annuitant who was enrolled in FEHB, and whose annuity terminated due to restoration of earning capacity or recovery from disability, and whose annuity is restored; • Compensationer whose compensation terminated because of recovery from injury or disease and whose compensation is restored due to a recurrence of medical condition; • Surviving spouse who was covered by FEHB immediately before survivor annuity terminated because of remarriage and whose annuity is restored; • Surviving child who was covered by FEHB immediately before survivor annuity terminated because student status ended and whose survivor annuity is restored; • Surviving child who was covered by FEHB immediately before survivor annuity terminated because of marriage and whose survivor annuity is restored.	Yes	N/A	N/A	Within 60 days after the retirement system or OWCP mails a notice of insurance eligibility.
2F	Annuitant or eligible family member loses FEHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
2G	Annuitant or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see events 2C and 2D); • Loss of coverage under a non-Federal health plan.	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
2H	Annuitant or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
2I	Annuitant or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
2J	Employee in an overseas post of duty retires or dies.	No	Yes	Yes	Within 60 days after retirement or death.
2K	An enrolled annuitant separates from duty after serving 31 days or more in a uniformed service.	N/A	Yes	Yes	Within 60 days after separation from the uniformed service.
2L	On becoming eligible for Medicare. (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
2M	Annuitant's annuity is insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Employing office will advise annuitant of the options.
3	**Former Spouse Under The Spouse Equity Provisions** ***Note:*** Former spouse may change to Self and Family only if family members are also eligible family members of the employee or annuitant.				
3A	Initial opportunity to enroll. Former spouse must be eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615), as amended, the Intelligence Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).	Yes	N/A	N/A	Generally, must apply within 60 days after dissolution of marriage. However, if a retiring employee elects to provide a former spouse annuity or insurable interest annuity for the former spouse, the former spouse must apply within 60 days after OPM's notice of eligibility for FEHB. May enroll any time after employing office establishes eligibility.
3B	Open Season.	No	Yes	Yes	As announced by OPM.
3C	Change in family status based on addition of family members who are also eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after change in family status.
3D	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare-sponsored plan, Medicaid, or similar State-sponsored program and who later was ***involuntarily*** disenrolled from the Medicare-sponsored plan, Medicaid, or similar State-sponsored program.	May reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment.
3E	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare-sponsored plan, Medicaid, or similar State-sponsored program and who later ***voluntarily*** disenrolls from the Medicare-sponsored plan, Medicaid, or similar State-sponsored program.	May reenroll	N/A	N/A	During open season.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
3F	Former spouse or eligible child loses FEHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.
3G	Enrolled former spouse or eligible child loses coverage under another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see 3D and 3E); • Loss of coverage under a non-Federal health plan.	N/A	Yes	Yes	From 31 days before through 60 days after loss of coverage.
3H	Former spouse or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
3I	Former spouse or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
3J	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning the 30th day before becoming eligible for Medicare.
3K	Former spouse's annuity is insufficient to make FEHB withholdings for plan in which enrolled.	No	No	Yes	Retirement system will advise former spouse of options.
4	**Temporary Continuation of Coverage (TCC) For Eligible Former Employees, Former Spouses, and Children.** ***Note:*** Former spouse may change to Self and Family only if family members are also eligible family members of the employee or annuitant.				
4A	Opportunity to enroll for continued coverage under TCC provisions: • Former employee • Former spouse • Child who ceases to qualify as a family member	 Yes Yes Yes	 Yes N/A N/A	 Yes N/A N/A	Within 60 days after the qualifying event, or receiving notice of eligibility, whichever is later.
4B	Open Season: • Former employee • Former spouse • Child who ceases to qualify as a family member	 No No No	 Yes Yes Yes	 Yes Yes Yes	As announced by OPM.
4C	Change in family status (except former spouse); for example, marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after event.
4D	Change in family status of former spouse, based on addition of family members who are eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after event.
4E	Reenrollment of a former employee, former spouse, or child whose TCC enrollment was terminated because of other FEHB coverage and who loses the other FEHB coverage before the TCC period of eligibility (18 or 36 months) expires.	May reenroll	N/A	N/A	From 31 days before through 60 days after the event. Enrollment is retroactive to the date of the loss of the other FEHB coverage.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
4F	Enrollee or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment (but see event 4E); • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-Federal health plan.	No	Yes	Yes	From 31 days before through 60 days after loss of coverage.
4G	Enrollee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
4H	Enrollee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
4I	On becoming eligible for Medicare. (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
5	**Employees Who Are Not Participating In Premium Conversion**				
5A	Initial opportunity to enroll.	Yes	N/A	N/A	Within 60 days after becoming eligible.
5B	Open Season.	Yes	Yes	Yes	As announced by OPM.
5C	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce	Yes	Yes	Yes	From 31 days before through 60 days after event.
5D	Change in employment status; for example: • Reemployment after a break in service of more than 3 days; • Return to pay status following loss of coverage due to expiration of 365 days of LWOP status or termination of coverage during LWOP; • Return to pay sufficient to make withholdings after termination of coverage during a period of insufficient pay; • Restoration to civilian position after serving in uniformed services; • Change from temporary appointment to appointment that entitles employee receipt of Government contribution; • Change to or from part-time career employment.	Yes	Yes	Yes	Within 60 days of employment status change.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
5E	Separation from Federal employment when the employee is or employee's spouse is pregnant.	Yes	Yes	Yes	Enrollment or change must occur during final pay period of employment.
5F	Transfer from a post of duty within the United States to a post of duty outside the United States, or reverse.	Yes	Yes	Yes	From 31 days before leaving old post through 60 days after arriving at new post.
5G	Employee or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment; • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-Federal health plan.	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
5H	Enrollee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
5I	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-federally employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area through 180 days after arriving in the new commuting area.
5J	Employee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside the area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
5K	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
5L	Temporary employee completes one year of continuous service in accordance with 5 U.S.C. Section 8906a.	Yes	N/A	N/A	Within 60 days after becoming eligible.
5M	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Within 60 days after receiving notice from employing office.

FEHB

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
4. Sex ☐ M ☐ F
5. Are you married? ☐ Yes ☐ No
6. Home mailing address *(including ZIP Code)*
7. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
8. TRICARE ☐
9. Other insurance ☐
10. Name of insurance
11. Insurance policy no.

12. Name of family member *(last, first, middle initial)*
13. Social Security number
14. Date of birth
15. Sex ☐ M ☐ F
16. Relationship code
17. Address *(if different from enrollee)*
18. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
19. TRICARE ☐
20. Other insurance ☐
21. Name of insurance
22. Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Part B - Present Plan

1. Plan name
2. Enrollment code

Part C - New Plan

1. Plan name
2. Enrollment code

Part D - Event Code

1. Event code
2. Date of event __ __ / __ __ / __ __ __ __

Part E - Employees Only (Election NOT to Enroll)

☐ 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

☐ 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 (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. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS

1. Date received
2. Effective date of action
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

This edition supersedes all previous editions of SF 2809 and SF 2809-1.

U.S. Office of Personnel Management

NSN 7540-01-231-6227

Copy 1 - Official Personnel Folder

Standard Form 2809
Revised October 2004
Previous editions are not usable.

Print Form | Save Form | Clear Form

Form Approved:
OMB No. 3206-0160

FEHB
Federal Employees
Health Benefits Program

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	4. Sex ☐ M ☐ F	5. Are you married? ☐ Yes ☐ No
6. Home mailing address *(including ZIP Code)*		7. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D	8. TRICARE ☐	9. Other insurance ☐
		10. Name of insurance		11. Insurance policy no.
12. Name of family member *(last, first, middle initial)*	13. Social Security number	14. Date of birth	15. Sex ☐ M ☐ F	16. Relationship code
17. Address *(if different from enrollee)*		18. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D	19. TRICARE ☐	20. Other insurance ☐
		21. Name of insurance		22. Insurance policy no.
Name of family member *(last, first, middle initial)*	Social Security number	Date of birth	Sex ☐ M ☐ F	Relationship code
Address *(if different from enrollee)*		Medicare *(See note - page 2)* ☐ A ☐ B ☐ D	TRICARE ☐	Other insurance ☐
		Name of insurance		Insurance policy no.
Name of family member *(last, first, middle initial)*	Social Security number	Date of birth	Sex ☐ M ☐ F	Relationship code
Address *(if different from enrollee)*		Medicare *(See note - page 2)* ☐ A ☐ B ☐ D	TRICARE ☐	Other insurance ☐
		Name of insurance		Insurance policy no.
Name of family member *(last, first, middle initial)*	Social Security number	Date of birth	Sex ☐ M ☐ F	Relationship code
Address *(if different from enrollee)*		Medicare *(See note - page 2)* ☐ A ☐ B ☐ D	TRICARE ☐	Other insurance ☐
		Name of insurance		Insurance policy no.

Part B - Present Plan

1. Plan name
2. Enrollment code

Part C - New Plan

1. Plan name
2. Enrollment code

Part D - Event Code

1. Event code
2. Date of event

Part E - Employees Only (Election NOT to Enroll)

☐ 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

☐ 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 (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. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS

1. Date received	2. Effective date of action	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	

This edition supersedes all previous editions of SF 2809 and SF 2809-1.

U.S. Office of Personnel Management

NSN 7540-01-231-6227

Copy 2- New Carrier

Standard Form 2809
Revised October 2004
Previous editions are not usable.

Print Form Save Form Clear Form

FEHB
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
4. Sex ☐ M ☐ F
5. Are you married? ☐ Yes ☐ No
6. Home mailing address *(including ZIP Code)*
7. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
8. TRICARE ☐
9. Other insurance ☐
10. Name of insurance
11. Insurance policy no.

12. Name of family member *(last, first, middle initial)*
13. Social Security number
14. Date of birth
15. Sex ☐ M ☐ F
16. Relationship code
17. Address *(if different from enrollee)*
18. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
19. TRICARE ☐
20. Other insurance ☐
21. Name of insurance
22. Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Part B - Present Plan

1. Plan name
2. Enrollment code

Part C - New Plan

1. Plan name
2. Enrollment code

Part D - Event Code

1. Event code
2. Date of event

Part E - Employees Only (Election NOT to Enroll)

☐ 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

☐ 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 (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. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS

1. Date received
2. Effective date of action
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

This edition supersedes all previous editions of SF 2809 and SF 2809-1.
U.S. Office of Personnel Management
NSN 7540-01-231-6227
Copy 3 - Old Carrier
Standard Form 2809
Revised October 2004
Previous editions are not usable.

Print Form | Save Form | Clear Form

Form Approved:
OMB No. 3206-0160

FEHB
Federal Employees
Health Benefits Program

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
4. Sex: M F
5. Are you married? Yes No
6. Home mailing address *(including ZIP Code)*
7. Medicare *(See note - page 2)* A B D
8. TRICARE
9. Other insurance
10. Name of insurance
11. Insurance policy no.

12. Name of family member *(last, first, middle initial)*
13. Social Security number
14. Date of birth
15. Sex: M F
16. Relationship code
17. Address *(if different from enrollee)*
18. Medicare *(See note - page 2)* A B D
19. TRICARE
20. Other insurance
21. Name of insurance
22. Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex: M F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* A B D | TRICARE | Other insurance
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex: M F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* A B D | TRICARE | Other insurance
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex: M F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* A B D | TRICARE | Other insurance
Name of insurance | Insurance policy no.

Part B - Present Plan

1. Plan name
2. Enrollment code

Part C - New Plan

1. Plan name
2. Enrollment code

Part D - Event Code

1. Event code
2. Date of event

Part E - Employees Only (Election NOT to Enroll)

☐ 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

☐ 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 (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. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS

1. Date received
2. Effective date of action
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

This edition supersedes all previous editions of SF 2809 and SF 2809-1.

NSN 7540-01-231-6227

U.S. Office of Personnel Management

Copy 4 - Payroll Office

Standard Form 2809
Revised October 2004
Previous editions are not usable.

Print Form | Save Form | Clear Form

FEHB
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
4. Sex ☐ M ☐ F
5. Are you married? ☐ Yes ☐ No
6. Home mailing address *(including ZIP Code)*
7. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
8. TRICARE ☐
9. Other insurance ☐
10. Name of insurance
11. Insurance policy no.

12. Name of family member *(last, first, middle initial)*
13. Social Security number
14. Date of birth
15. Sex ☐ M ☐ F
16. Relationship code
17. Address *(if different from enrollee)*
18. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
19. TRICARE ☐
20. Other insurance ☐
21. Name of insurance
22. Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Part B - Present Plan

1. Plan name
2. Enrollment code

Part C - New Plan

1. Plan name
2. Enrollment code

Part D - Event Code

1. Event code
2. Date of event __ __ / __ __ / __ __ __ __

Part E - Employees Only (Election NOT to Enroll)

☐ 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

☐ 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 (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. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS

1. Date received
2. Effective date of action
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

Print Form | Save Form | Clear Form