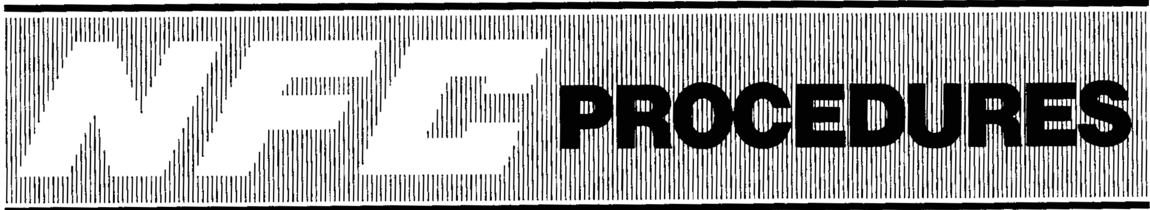


U.S. Department of Agriculture • Office of Finance and Management • National Finance Center • June 1990

DIRECT PREMIUM REMITTANCE SYSTEM (DPRS)

Title III
BILLINGS AND COLLECTIONS MANUAL

Chapter 5
DIRECT PREMIUM REMITTANCE SYSTEM

Table of Contents

Page

1. Introduction 1
2. Responsibilities 2
3. Forms 3
4. Enrollment 3
5. Transfers 4
6. Corrections 4
7. Reports 5
8. Inquiries 5

Exhibits 7

Forms for New Enrollees 9

1. SF-2809 for Initial Enrollment of a Child of a Current Employee 10
2. SF-2809 for Enrollment of a Separated Employee 11
3. SF-2809 for Initial Enrollment of Former Spouse of Current Employee 12
4. SF-2809 for Former Spouse under P.L. 98-615 13

Forms for Transfer Enrollees 15

5. SF-2810 for the Transfer Out from an Agency to NFC 16
6. DPRS Form 20 17
7. Original SF-2809 for Enrollment 18
8. SF-2810 for Transfer of up to 25 Enrollees to the Same Enrollment Code on the Same Day 19

Forms for Corrections 21

9. SF-2809 for Correction of an Erroneous Enrollment Code 22
10. SF-2809 to Correct an Erroneous Effective Date 23
11. SF-2809 to Correct an Erroneous Public Law 24

Reports 25

12. Report DPRS1501, Report of SF-2809's, 2810's Processed 26
13. Report DPRS1601, Notice of Individual Retirement Change for Spouse Equity 27

Appendixes 29

1. Instructions for Completing SF-2809 31
2. Instructions for Completing SF-2810 41

(reserved)

1. Introduction

This procedure provides instructions for Federal agencies to enroll eligible non–Federally employed individuals in the Direct Premium Remittance System (DPRS). DPRS is a centralized system for collecting premiums from eligible non-Federal enrollees who elect to participate in the Federal Employees Health Benefits (FEHB) Program under Public Law (P.L.) 98–615, the Civil Service Retirement Spouse Equity Act of 1984, and Title II of P.L. 100–654 (5 USC 8905a), the Federal Employees Health Benefits Amendments Act of 1988. A summary of the responsibilities of the agencies, NFC, and the DPRS enrollees is provided in Figure 1.

Public Law 98–615 provides for certain former spouses of current, retired, or separated Federal employees to enroll in the FEHB Program. Title II of Public Law 100–654 provides for temporary continuation of coverage under the Federal Employees Health Benefits (FEHB) Program to be available to (1) certain individuals who separate from Federal service, (2) children (of either Federal employees or annuitants) who lose their status as family members, and (3) certain former spouses of Federal employees or annuitants who would not otherwise be eligible for continued FEHB coverage.

Each of these laws establishes a requirement that agencies provide FEHB coverage for qualified enrollees. The OPM has contracted with the U.S. Department of Agriculture's National Finance Center (NFC) to act as the central processing office for P.L. 98–615 and P.L. 100–654 accounts. Those agencies that elect to use NFC's services will have their accounts processed through DPRS.

Annuitants will continue to be serviced by the Office of Personnel Management (OPM) or the appropriate retirement system.

Summary of DPRS Responsibilities	
To Transfer Existing Accounts	
Agencies	Prepare and process SF–2810. Forward copy of SF–2810, OPF copy of initial SF–2809 & DPRS Form 20 to NFC
NFC	Establish each transferred enrollee into DPRS Generate SF–2810 copy to FEHB carrier Forward enrollee coupon book for making payments through lock box. Monitor enrollee accounts Provide reporting to OPM and carrier
To Establish a New Enrollment	
Agencies	Advise eligible individuals of coverage available under P.L. 98–615 & P.L 100–654
Eligible Enrollees	Prepare SF–2809 & forward to agency
Agencies	Complete SF–2809 & forward to NFC
NFC	Establish enrollee into DPRS Generate SF–2809 copy to FEHB carrier Forward enrollee coupon book for making payments through lock box Monitor enrollee accounts Provide reporting to OPM and carrier
Change/Cancel/Terminate an Enrollment	
Enrollee	Prepare SF–2809 and forward to NFC
NFC	Process or generate SF–2809/SF–2810 to accomplish change, cancellation, or termination

Figure 1. Summary of DPRS responsibilities

2. Responsibilities

Agency submitting offices will:

- Inform separating employees of their eligibility and that of children and former spouses under the expanded FEHB coverage.
- Inform separating employees of the eligibility time restraints imposed under the expanded FEHB coverage. (See FPM Bulletins 890–179 and 890–186 for information on eligibility.)
- Determine the eligibility of separated employees, children, and former spouses of **current employees** for the expanded FEHB coverage. (See FPM 890–179 and 890–186 for information on eligibility.)
- Determine the eligibility of separated employees, children, and former spouses to enroll under the **requested** plan. (Some have signed for HMOs for which they are not eligible.)
- Receive the initial SF–2809, Health Benefits Registration Form, from the enrollee and ensure that the information is accurate and complete, and **signed by both the enrollee and an agency official**.
- Complete the agency portion of the SF–2809, by identifying the public law covering the enrollee (either P.L. 98–615 – Spouse Equity Act, or P.L. 100–654 – Temporary Continuation (5 USC 8905a)), their submitting office number, date of qualifying event, and additional information regarding the original employee.
- **Return the enrollee's copy** of the SF–2809 and/or SF–2810, Notice of Change in Health Benefit Enrollment, to the enrollee, **keep the new carrier copy for its records,** and send the rest of the form to NFC for processing.
- Prepare the SF–2810 and attach the initial SF–2809 with the additional enrollment information required (See Sec. 5) for the transfer in of Spouse Equity Act enrollees to NFC.
- Forward SF–2809 and SF–2810 to NFC.
- Respond to inquiries from NFC personnel relating to the initial SF–2809 and data submitted for new enrollees.
- If SF–2809 version is printed prior to June 1988, include enrollee and agency telephone numbers, and effective date of "Other Insurance."
- Review the monthly Report DPRS1501 to ensure that all SF–2809's submitted by their office have been processed correctly.
- Forward semi–monthly report DPRS 1601 to retirement section of agency payroll office.
- Submit any corrections to the initial SF–2809 or SF–2810 as a result of an administrative error.
- Explain to the enrollee that they must pay the total cost of the coverage (their share and the amount the government normally contributes for an employee).
- Advise the enrollee to plan for any normal medical needs (especially with HMOs). There could be a delay of 30–45 days before an enrollee is established on the carrier's system. The NFC sends information to the carriers on the first and fifteenth. It takes the carriers at least two weeks after receipt to establish them on their system. Also, NFC will bill the enrollee on the first of the month following the latter of the effective date of coverage or the date established in our system.

NFC will:

- Receive and process the initial SF–2809 and all SF–2810 forms (transfer–out) from submitting offices.
- Determine the eligibility of former spouses (except those applying under the Spouse Equity Act) and children of **separated employees** (on our System) applying for enrollment under the expanded FEHB coverage based upon guidelines as provided in the FPM 890–1.
- Establish and maintain enrollee accounts.

- Respond to billing and collection inquiries.
- Determine eligibility for subsequent changes in enrollment for all categories of enrollees.
- Handle open season processing.
- Coordinate the transfer of Temporary Continuation and Spouse Equity enrollees.
- Determine the eligibility for reinstatement of an enrollee.
- Provide enrollees with correspondence relating to their enrollment in the Direct Premium Remittance System after their initial enrollment.

3. Forms

The following forms are used in DPRS:

- SF–2809, Health Benefits Registration
- SF–2810, Notice of Change in Health Benefits Enrollment.
- Form DPRS20, Attachment to SF–2809 for Transfer In.

4. Enrollment

Individuals who are eligible for extended FEHB coverage under P.L. 98-615 or P.L. 100-654 will apply for initial enrollment by providing their agency submitting offices with a completed SF-2809, Health Benefits Registration Form. (See Exhibits for examples of completed SF–2809s. For **instructions** on filling out the SF-2809, see the Appendix 1.

Prior to forwarding the initial SF-2809 document to NFC for processing, the agency must type the following information on the form:

- The effective date of the enrollment.
- The submitting office number (SON) in Part G, Block 1. (This is **very important**, as the document will fail processing if the SON is missing or incorrect, and enrollment of the applicant may be delayed.)
- The following information must be included in the Remarks block **in exactly the order shown** as appropriate for the class of the enrollee:

  Separated employee:

  - Relationship (self)
  - The public law under which the applicant is eligible, using the law's whole number; i.e., P.L. 100-654 (5 USC 8905a).
  - Date of separation
  - Last day of pay period

  Former spouse and child of a current employee:

  - Relationship (ex–spouse, child)
  - The Public Law under which the applicant is eligible for benefits, using the law's whole number; i.e., P.L. 98-615 or P.L. 100-654 (5 USC 8905a).
  - Name of the employee
  - Social security number of the employee
  - Date of birth of the employee
  - Date of the qualifying event; i.e, divorce, annulment, (date of 22nd birthday), etc. (P.L. 100-654 enrollees only.)

  Former spouse and child of a separated employee:

  Persons in this category should contact NFC directly for enrollment information.

  Former spouse and child of Civil Service Retirement System (CSRS), Federal Employees Retirement System (FERS), or other retirement systems' annuitants:

The Office of Personnel Management (OPM) will continue to process any accounts for **their** annuitants' children or former spouses. Forms

for these individuals should be sent to OPM, **not** to NFC.

The original employee/former employee information will be needed to establish a DPRS enrollee master, to determine the enrollment expiration date in the case of P.L. 100–654 enrollees, and to provide this information to the carrier.

After all information is complete, the submitting office should **return the enrollee's copy** to the enrollee, **keep the new carrier copy** for its records, and send the rest of the package to NFC for processing at the following address:

National Finance Center
DPRS Billing Unit
P.O. Box 61760
New Orleans, LA 70161-1760

Upon receipt of the initial SF–2809 for enrollment into a plan, NFC will process and generate a copy of the SF–2809 to the carrier and establish an enrollee master on the DPRS data base.

5. Transfers

Agencies that are maintaining **existing** P.L. 98-615 and P.L. 100-654 (5 USC 8905a) accounts within their own systems may transfer those accounts to NFC. (Do **not** transfer an employee when they separate from your employment. These employees should be terminated, and then submitted to NFC as a new enrollment.)

When transferring an existing account, conversion of billing from the original agency to NFC must be coordinated. Agencies should call the DPRS Billing Unit at NFC at (FTS) **680-5990** or (Commercial) **504-255-5990** for more information.

The agencies will prepare, process, and distribute a SF-2810 documenting the transfer out of the agencies' DPRS processing to NFC. In addition to the SF–2810, the agencies will provide NFC with the OPF copy of the initial SF–2809 and a DPRS Form 20 for each enrollee. (See Exhibits 5–8 for examples. A blank form DPRS–20 is included for local reproduction. See Exhibits for examples of completed SF–2810s. For **instructions** on filling out the SF-2810, see Appendix 2.) P.L. 98–615 enrollee Health Benefits files should be sent to NFC under separate cover.

Based on receipt of these forms from the agencies, NFC will prepare SF–2810's to transfer in these enrollees and will establish an account for each enrollee involved in the transfer. **No active accounts with an overdue premium should be transferred in to NFC until the overdue amount has been collected.**

Up to 25 enrollees may be transferred at one time on a single SF-2810. (For groups larger than 25, prepare a SF-2810 for each 25 enrollees.) A separate SF-2810 is required for each enrollment option category (Self or Self and Family.) For each enrollment code, the submitting office will prepare a SF-2810 for the transfer group and will attach an initial SF-2809 and a DPRS Form 20 for each individual to be transferred. These documents are the basis for preparing SF-2810's for the individual transfers and establishing DPRS enrollee masters. Agencies should verify the address and phone number on the SF–2809 for accuracy. Any updates should be noted on the form DPRS20.

Send the completed forms and/or files to:

National Finance Center
DPRS Billing Unit
P.O. Box 61760
New Orleans, LA 70161–1760

6. Corrections

The following information is provided for agencies to make corrections **only if the initial SF-2809 or SF-2810 is incorrectly prepared.** Agencies will not be responsible for any other corrections.

Correction processing is necessary where the erroneous information given on the SF–2809 or the SF–2810 affects a person's entitlement, e.g., errors in enrollee's name, social security number, or family members, enrollment code, effective date, or similar errors. Depending on the type of error and who became aware of it, NFC either receives a completed SF–2809 or SF–2810 from the agency for processing, or NFC prepares and

processes an SF–2809 or SF–2810 to correct the error. The SF–2809 or SF–2810 must be clearly labeled "correction," must include the enrollee's name, social security number, and other identifying information (see Exhibits 9–11 for examples), and should show the items to be corrected. The forms are processed and copies distributed as described in the appropriate sections above. Also, NFC will send each affected carrier the appropriate copy of the corrected SF–2809.

Voiding a document is appropriate when an incorrect enrollment action must be withdrawn. If the SF–2809 or the SF–2810 of the enrollment to be voided is in the possession of NFC but is not processed, all copies of the forms are returned to the agency.

If the incorrect action was processed, the personnel office should send a corrected SF–2809 or SF–2810 to NFC indicating the erroneous information in the Remarks block. (See Exhibits 9–11.) The enrollee copy should be sent to the enrollee. NFC will perform the necessary actions to "void" the SF–2809 or SF–2810 action that was erroneously processed. NFC will generate the respective carrier copy (under cover of the SF–2811, Transmittal and Summary Report to Carrier transmittal).

7. Reports

NFC will maintain records in such a manner as to facilitate the prompt and accurate updating of accounts and summarization for financial reporting to OPM. NFC will maintain adequate controls to ensure the accuracy of the remittances by each enrollment code.

NFC will assume the responsibility for providing OPM with the following reports:

- **SF–2812** – Report of Withholdings and Contributions for Retirement, Health Benefits, and Group Life Insurance.
- **SF–2812A** – Report of Withholdings and Contributions for Health Benefits by Enrollment Code.
- **OPM 1523** – Semiannual Headcount Reporting.

NFC will assume responsibility for providing the FEHB carriers with the SF–2811. At the request of an FEHB carrier, NFC will provide a magnetic tape and/or list of plan enrollees. Carriers will use the list in their reconciliation of enrollees. In the case of a discrepancy, NFC will be notified by the carrier and asked to provide the necessary documentation (normally, copies of the SF–2809 or SF–2810) to resolve the problem.

For verification purposes, NFC will provide each submitting office with a report (DPRS 1501) giving information on all initial SF-2809/SF-2810 activity processed in the previous monthly cycle. (See Exhibit 12 for an example of DPRS 1501.)

NFC will provide each submitting office with a report (DPRS1601) indicating any changes, terminations, or cancellations in enrollment for Spouse Equity Accounts. This report **should be forwarded** to the retirement section of the payroll office to note on the employee's retirement master record (SF–2806/SF–3100) or supplemental record (SF–2806–1/SF–3101) any spouse equity enrollments, cancellations, terminations, or reinstatements. (See Subchapter 17 of FPM Supplement 890-1 for more information. See Exhibit 13 for an example of DPRS1601.)

8. Inquiries

All questions from enrollees and/or their agencies regarding their accounts should be referred to and will be handled by NFC, except those relating to the eligibility of separated employees and former spouses/children of current employees. Eligibility questions in these areas will be handled by the submitting office.

NFC may refer a question/problem to the "Health Officer" of the employing agency for final ruling or clarification through appropriate channel to the Office of Personnel Management.

NFC has established a toll free telephone inquiry line for DPRS enrollees. The number is **1-800-242–9630**. The line is available from 7:45 a.m. to 4:00 p.m., Central Time, Monday through Friday (except Federal holidays).

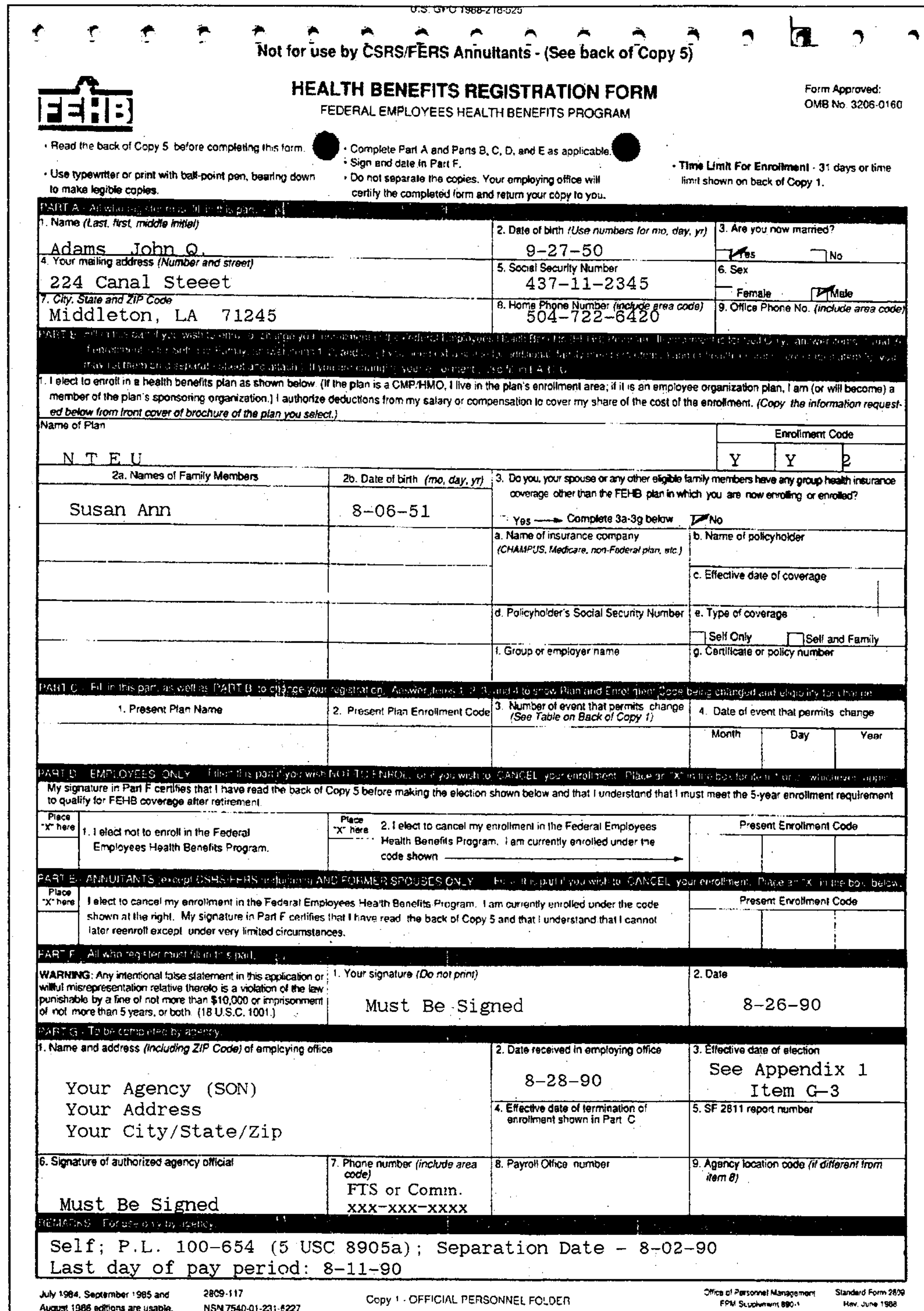
Submitting Offices **without FTS** may use the toll–free telephone number, or call (Commercial) **504–255–5990**. Submitting Offices with FTS service should call (FTS) **680–5990** or (Commercial) **504–255–5990**. Please use FTS if it is available to you.

The inquiry line is available from 7:45 a.m. to 4:00 p.m., Central Time, Monday through Friday (except Federal holidays).

Exhibits

(reserved)

Forms for New Enrollees



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FEHB

HEALTH BENEFITS REGISTRATION FORM
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Form Approved:
OMB No. 3206-0160

- Read the back of Copy 5 before completing this form.
- Use typewriter or print with ball-point pen, bearing down to make legible copies.
- Complete Part A and Parts B, C, D, and E as applicable.
- Sign and date in Part F.
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- **Time Limit For Enrollment** - 31 days or time limit shown on back of Copy 1.

PART A - All who register must fill in this part.

1. Name *(Last, first, middle initial)*	2. Date of birth *(Use numbers for mo, day, yr)*	3. Are you now married?
Adams John Q.	9-27-50	[✓] Yes [ ] No
4. Your mailing address *(Number and street)*	5. Social Security Number	6. Sex
224 Canal Steeet	437-11-2345	[ ] Female [✓] Male
7. City, State and ZIP Code	8. Home Phone Number *(include area code)*	9. Office Phone No. *(include area code)*
Middleton, LA 71245	504-722-6420	

PART B - [illegible]

1. I elect to enroll in a health benefits plan as shown below. (If the plan is a CMP/HMO, I live in the plan's enrollment area; if it is an employee organization plan, I am (or will become) a member of the plan's sponsoring organization.) I authorize deductions from my salary or compensation to cover my share of the cost of the enrollment. *(Copy the information requested below from front cover of brochure of the plan you select.)*

Name of Plan	Enrollment Code		
N T E U	Y	Y	2

2a. Names of Family Members	2b. Date of birth *(mo, day, yr)*
Susan Ann	8-06-51

3. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled?
[ ] Yes → Complete 3a-3g below [✓] No

a. Name of insurance company *(CHAMPUS, Medicare, non-Federal plan, etc.)*	b. Name of policyholder
	c. Effective date of coverage
d. Policyholder's Social Security Number	e. Type of coverage [ ] Self Only [ ] Self and Family
f. Group or employer name	g. Certificate or policy number

PART C - Fill in this part, as well as PART B, to change your registration. Answer items 1, 2, 3, and 4 to show Plan and Enrollment Code being changed and eligibility for change.

1. Present Plan Name	2. Present Plan Enrollment Code	3. Number of event that permits change *(See Table on Back of Copy 1)*	4. Date of event that permits change — Month	Day	Year

PART D - EMPLOYEES ONLY - Fill in this part if you wish NOT TO ENROLL or if you wish to CANCEL your enrollment. Place an "X" in the box for item 1 or 2, whichever applies.

My signature in Part F certifies that I have read the back of Copy 5 before making the election shown below and that I understand that I must meet the 5-year enrollment requirement to qualify for FEHB coverage after retirement.

[ ] Place "X" here — 1. I elect not to enroll in the Federal Employees Health Benefits Program.

[ ] Place "X" here — 2. I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown → Present Enrollment Code: ____

PART E - ANNUITANTS (except CSRS/FERS annuitants) AND FORMER SPOUSES ONLY - Fill in this part if you wish to CANCEL your enrollment. Place an "X" in the box below.

[ ] Place "X" here — I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right. My signature in Part F certifies that I have read the back of Copy 5 and that I understand that I cannot later reenroll except under very limited circumstances. Present Enrollment Code: ____

PART F - All who register must fill in this part.

WARNING: Any intentional 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
	Must Be Signed	8-26-90

PART G - To be completed by agency.

1. Name and address *(Including ZIP Code)* of employing office	2. Date received in employing office	3. Effective date of election
Your Agency (SON) Your Address Your City/State/Zip	8-28-90	See Appendix 1 Item G-3
	4. Effective date of termination of enrollment shown in Part C	5. SF 2811 report number

6. Signature of authorized agency official	7. Phone number *(include area code)*	8. Payroll Office number	9. Agency location code *(if different from item 8)*
Must Be Signed	FTS or Comm. xxx-xxx-xxxx		

REMARKS - For use only by agency.

Self; P.L. 100-654 (5 USC 8905a); Separation Date - 8-02-90
Last day of pay period: 8-11-90

July 1984, September 1985 and August 1986 editions are usable. 2809-117 NSN 7540-01-231-6227 Copy 1 - OFFICIAL PERSONNEL FOLDER Office of Personnel Management FPM Supplement 890-1 Standard Form 2809 Rev. June 1988

U.S. GPO 1988-210-525

Not for use by CSRS/FERS Annuitants - (See back of Copy 5)

HEALTH BENEFITS REGISTRATION FORM

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Form Approved:
OMB No. 3206-0160

- Read the back of Copy 5 before completing this form.
- Use typewriter or print with ball-point pen, bearing down to make legible copies.
- Complete Part A and Parts B, C, D, and E as applicable.
- Sign and date in Part F.
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- **Time Limit For Enrollment** - 31 days or time limit shown on back of Copy 1.

PART A - All who register must fill in this part.

1. Name *(Last, first, middle initial)*	2. Date of birth *(Use numbers for mo, day, yr)*	3. Are you now married?
Smith Michael T.	8-28-68	☐ Yes ☒ No
4. Your mailing address *(Number and street)*	5. Social Security Number	6. Sex
112 Main Street	437-64-1234	☐ Female ☒ Male
7. City, State and ZIP Code	8. Home Phone Number *(include area code)*	9. Office Phone No. *(include area code)*
Jonesville, LA 71234	504-722-7890	

PART B - [illegible]

1. I elect to enroll in a health benefits plan as shown below. (If the plan is a CMP/HMO, I live in the plan's enrollment area; if it is an employee organization plan, I am (or will become) a member of the plan's sponsoring organization.) I authorize deductions from my salary or compensation to cover my share of the cost of the enrollment. *(Copy the information requested below from front cover of brochure of the plan you select.)*

Name of Plan	Enrollment Code		
Blue Cross and Blue Shield	1	0	4

2a. Names of Family Members	2b. Date of birth *(mo, day, yr)*

3. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled?
☐ Yes → Complete 3a-3g below ☒ No

a. Name of insurance company *(CHAMPUS, Medicare, non-Federal plan, etc.)*	b. Name of policyholder
	c. Effective date of coverage
d. Policyholder's Social Security Number	e. Type of coverage ☐ Self Only ☐ Self and Family
f. Group or employer name	g. Certificate or policy number

PART C - Fill in this part, as well as PART B to change your registration. Answer items 1, 2, 3, and 4 to show Plan and Enrollment Code being changed and eligibility for change.

1. Present Plan Name	2. Present Plan Enrollment Code	3. Number of event that permits change *(See Table on Back of Copy 1)*	4. Date of event that permits change: Month	Day	Year

PART D - EMPLOYEES ONLY - Fill in this part if you wish NOT TO ENROLL or if you wish to CANCEL your enrollment. Place an "X" in the box for item 1 or 2 [illegible]

My signature in Part F certifies that I have read the back of Copy 5 before making the election shown below and that I understand that I must meet the 5-year enrollment requirement to qualify for FEHB coverage after retirement.

Place "X" here		Place "X" here		Present Enrollment Code
	1. I elect not to enroll in the Federal Employees Health Benefits Program.		2. I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown →	

PART E - ANNUITANTS (except CSRS/FERS) [illegible] AND FORMER SPOUSES ONLY - Fill in this part if you wish to CANCEL your enrollment. Place an "X" in the box below.

Place "X" here		Present Enrollment Code
	I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right. My signature in Part F certifies that I have read the back of Copy 5 and that I understand that I cannot later reenroll except under very limited circumstances.	

PART F - All who register must fill in this part.

WARNING: Any intentional 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
	Must Be Signed	9-2-90

PART G - To be completed by agency

1. Name and address *(including ZIP Code)* of employing office	2. Date received in employing office	3. Effective date of election
Your Agency (SON) Your Address Your City/State/Zip	9-4-90	See Appendix 1 Item G-3
	4. Effective date of termination of enrollment shown in Part C	5. SF 2811 report number

6. Signature of authorized agency official	7. Phone number *(include area code)*	8. Payroll Office number	9. Agency location code *(if different from item 8)*
Must Be Signed	FTS or Comm XXX-XXX-XXXX		

REMARKS - For use by agency

Child; P.L. 100-654 (5USC 8905a); Original Employee: Robert S. Smith, 516-12-3460, D.O.B. 12-22-48; Date of Qualifying Event: 8-28-90

July 1984, September 1985 and August 1986 editions are usable. 2809-117 NSN 7540-01-231-£227 Copy 1 - OFFICIAL PERSONNEL FOLDER Office of Personnel Management FPM Supplement 890-1 Standard Form 2809 Rev. June 1988

U.S. GPO 1988-218-525

Not for use by CSRS/FERS Annuitants - (See back of Copy 5)

HEALTH BENEFITS REGISTRATION FORM

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Form Approved:
OMB No. 3206-0160

- Read the back of Copy 5 before completing this form.
- Use typewriter or print with ball-point pen, bearing down to make legible copies.
- Complete Part A and Parts B, C, D, and E as applicable.
- Sign and date in Part F.
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- Time Limit For Enrollment - 31 days or time limit shown on back of Copy 1.

PART A - [illegible]

1. Name (Last, first, middle initial)	2. Date of birth (Use numbers for mo, day, yr)	3. Are you now married?
Abernathy Susan M.	2-14-53	Yes ☐ No ☒
4. Your mailing address (Number and street)	5. Social Security Number	6. Sex
101 Curry Court	438-22-3456	☒ Female ☐ Male
7. City, State and ZIP Code	8. Home Phone Number (include area code)	9. Office Phone No. (include area code)
Franklin, LA. 71123	504-722-7531	

PART B - [illegible]

1. I elect to enroll in a health benefits plan as shown below. (If the plan is a CMP/HMO, I live in the plan's enrollment area; if it is an employee organization plan, I am (or will become) a member of the plan's sponsoring organization.) I authorize deductions from my salary or compensation to cover my share of the cost of the enrollment. *(Copy the information requested below from front cover of brochure of the plan you select.)*

Name of Plan	Enrollment Code		
G E H A Benefit Plan	3	1	1

2a. Names of Family Members	2b. Date of birth (mo, day, yr)

3. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled?
☐ Yes → Complete 3a-3g below ☒ No

a. Name of insurance company (CHAMPUS, Medicare, non-Federal plan, etc.)	b. Name of policyholder
	c. Effective date of coverage
d. Policyholder's Social Security Number	e. Type of coverage ☐ Self Only ☐ Self and Family
f. Group or employer name	g. Certificate or policy number

PART C - Fill in this part as well as PART B to change your registration. [illegible]

1. Present Plan Name	2. Present Plan Enrollment Code	3. Number of event that permits change (See Table on Back of Copy 1)	4. Date of event that permits change: Month	Day	Year

PART D - EMPLOYEES ONLY - [illegible] CANCEL your enrollment. [illegible]

My signature in Part F certifies that I have read the back of Copy 5 before making the election shown below and that I understand that I must meet the 5-year enrollment requirement to qualify for FEHB coverage after retirement.

Place "X" here	1. I elect not to enroll in the Federal Employees Health Benefits Program.	Place "X" here	2. I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown →	Present Enrollment Code

PART E - ANNUITANTS (except CSRS/FERS annuitants) AND FORMER SPOUSES ONLY - [illegible] CANCEL your enrollment. [illegible]

Place "X" here	I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right. My signature in Part F certifies that I have read the back of Copy 5 and that I understand that I cannot later reenroll except under very limited circumstances.	Present Enrollment Code

PART F - All who register must fill in this part.

WARNING: Any intentional 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
	Must Be Signed	9-8-90

PART G - To be completed by agency

1. Name and address (including ZIP Code) of employing office	2. Date received in employing office	3. Effective date of election
Your Agency (SON) Your Address Your City/State/Zip	9-10-90	See Appendix 1 Item G-3
	4. Effective date of termination of enrollment shown in Part C	5. SF 2811 report number

6. Signature of authorized agency official	7. Phone number (include area code)	8. Payroll Office number	9. Agency location code (if different from item 8)
Must Be Signed	FTS or Comm XXX-XXX-XXXX		

REMARKS - For use by agency

Ex-Spouse; P.L. 100-654 (5 USC 8905a); Original Employee - James T. Abernathy, 443-22-1224, DOB 12-22-48, Date of Qualifying Event: 8-17-90

July 1984, September 1985 and August 1986 editions are usable. 2809-117 NSN 7540-01-231-6227 Copy 1 - OFFICIAL PERSONNEL FOLDER Office of Personnel Management FPM Supplement 890-1 Standard Form 2809 Rev. June 1988

Not for use by CSRS/FERS Annuitants - (See back of Copy 5)

HEALTH BENEFITS REGISTRATION FORM

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Form Approved: OMB No. 3206-0160

- Read the back of Copy 5 before completing this form.
- Use typewriter or print with ball-point pen, bearing down to make legible copies.
- Complete Part A and Parts B, C, D, and E as applicable.
- Sign and date in Part F.
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- Time Limit For Enrollment - 31 days or time limit shown on back of Copy 1.

PART A

1. Name (Last, first, middle initial)	2. Date of birth (Use numbers for mo, day, yr)	3. Are you now married?
Jackson Peggy S.	7-17-52	✓ Yes ☐ No
4. Your mailing address (Number and street)	5. Social Security Number	6. Sex
425 Milton Drive	433-76-5432	✓ Female ☐ Male
7. City, State and ZIP Code	8. Home Phone Number (include area code)	9. Office Phone No. (include area code)
Prairieville, TX 75112	801-750-1234	

PART B

1. I elect to enroll in a health benefits plan as shown below. (If the plan is a CMP/HMO, I live in the plan's enrollment area; if it is an employee organization plan, I am (or will become) a member of the plan's sponsoring organization.) I authorize deductions from my salary or compensation to cover my share of the cost of the enrollment. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of Plan	Enrollment Code
G E H A Benefit Plan	3 1 2

2a. Names of Family Members	2b. Date of birth (mo, day, yr)
Timothy James	5-13-79
Sue Ann	4-28-82

3. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? ☐ Yes → Complete 3a-3g below ✓ No

a. Name of insurance company (CHAMPUS, Medicare, non-Federal plan, etc.)
b. Name of policyholder
c. Effective date of coverage
d. Policyholder's Social Security Number
e. Type of coverage ☐ Self Only ☐ Self and Family
f. Group or employer name
g. Certificate or policy number

PART C

1. Present Plan Name	2. Present Plan Enrollment Code	3. Number of event that permits change (See Table on Back of Copy 1)	4. Date of event that permits change: Month / Day / Year

PART D EMPLOYEES ONLY

My signature in Part F certifies that I have read the back of Copy 5 before making the election shown below and that I understand that I must meet the 5-year enrollment requirement to qualify for FEHB coverage after retirement.

Place "X" here ☐ 1. I elect not to enroll in the Federal Employees Health Benefits Program.

Place "X" here ☐ 2. I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown →

Present Enrollment Code

PART E ANNUITANTS (except CSRS/FERS annuitants) AND FORMER SPOUSES ONLY

Place "X" here ☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right. My signature in Part F certifies that I have read the back of Copy 5 and that I understand that I cannot later reenroll except under very limited circumstances.

Present Enrollment Code

PART F All who register must fill in this part

WARNING: Any intentional 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): Must Be Signed	2. Date: 9-10-90

PART G To be completed by agency

1. Name and address (Including ZIP Code) of employing office	2. Date received in employing office	3. Effective date of election
Your Agency (SON) Your Address Your City/State/Zip	9-12-90	See Appendix 1 Item G-3
	4. Effective date of termination of enrollment shown in Part C	5. SF 2811 report number
6. Signature of authorized agency official: Must Be Signed	7. Phone number (include area code): FTS or Comm XXX-XXX-XXXX	8. Payroll Office number
		9. Agency location code (if different from item 8)

REMARKS For use only by agency

Ex-Spouse; P.L. 98-615; Original Employee - Michael T. Jackson, 443-12-7654; DOB 12-22-51

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(reserved)

Forms for Transfer Enrollees

U.S. GOVERNMENT PRINTING OFFICE: 1987-193-167/60889

Federal Employees Health Benefits Program

Notice of Change in Health Benefits Enrollment

Part A—Identifying Data

1. Name (Last, first, middle initial)	2. Date of Birth	3. Social Security Number
Plunkett Terry M.	8-10-53	512-34-5678
4. Address (including ZIP Code)	5. Payroll Office Number	6. Enrollment Code Number
319 Macon County Road Mount Elmo, MI	20-09-5790	311
	7. SF 2811 Report No.	8. Date This Action Becomes Effective
		See Appendix 2 Part A-8

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form unless your enrollment is terminated and you apply for conversion.

Part B—Termination

[ ] Your enrollment terminates on the date in Part A, item 8, above.
IMPORTANT NOTICE: YOU HAVE THE RIGHT TO CONVERT TO AN INDIVIDUAL CONTRACT WITH THE CARRIER OF YOUR PLAN. See **Part B—Termination** on the back of this form for information about your extension of coverage and conversion. If you want to convert, fill in the box on the back of this form and send it to your plan **within the time limit specified.**

Part C—Transfer Out

[X] This enrollment continues but is transferred to the new Payroll Office (or Retirement System) shown below. See Part C on the back of this form for more information.

USDA - National Finance Center
Direct Premium Remittance System

Part D—Transfer In

[ ] The new Payroll Office (or Retirement System) shown in Part I below has accepted transfer of this enrollment and will continue it.

Part E—Reinstatement

[ ] Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part F—Change in Name of Enrollee

[ ] The name in which this enrollment is carried has been changed to:
Name | Date of Birth
Address (including ZIP Code) if different from Part A, item 4, above.

Part G—Change in Enrollment—Survivor Annuitant

[ ] Your enrollment has been changed from family coverage to Self Only. Your plan will send you a new identification card. Your new enrollment code number is shown below.
(NOTE: This item is completed by Retirement Systems only.)

New Enrollment Code Number →

Part H—Remarks

Part I—Date of Notice
(NOTE: Instructions for Employing Offices are on the back of Copy 4 of this form.)

Name of Agency and Address (including ZIP Code)
Your Agency (SON)
Your Address
Your City/State/Zip

Signature of Authorized Agency Official		Date
Must Be Signed	Phone #	10-4-90

Office of Personnel Management
FPM Supplement 890-1
Previous editions not usable
NSN 7540-01-232-1234
2810-101
Copy 1 - To Enrollee
Standard Form 2810
Rev. January 1987

DIRECT PREMIUM REMITTANCE SYSTEM

Federal Employees Health Benefits Program

ACCOUNT INFORMATION TO SUPPORT TRANSFER IN

(Attachment to the original SF 2809)

A. GENERAL ENROLLEE INFORMATION. This section ***must*** be completed or this enrollee's application will be returned unprocessed.

1. NAME (Last, First, Middle Initial)	2. SOCIAL SECURITY NUMBER
Plunkett, Terry M.	512-34-5678
3. CURRENT MAILING ADDRESS (Number and Street) 121 Lisa Street	4. DAYTIME PHONE NUMBER (Number where the enrollee can be reached for questions concerning FEHB enrollment)
(City, State, and Zip Code) Mount Elmo, MI	313-326-1234

B. CURRENT HEALTH BENEFITS INFORMATION. Complete this section if applicable.

List current enrollment code and date if different from the attached SF 2809. Enrollment Code is the ***current*** code the enrollee is enrolled in for health benefits. Enrollment Code Date is the date the enrollee ***first*** enrolled under this enrollment code.

5. ENROLLMENT CODE	6. ENROLLMENT CODE DATE (Month, Day, Year)
(Current enrollment code)	(Enrollment Date of current code)

C. INSURANCE INFORMATION. Complete this section if applicable.

List all family members and dates of birth not included on the attached SF 2809. Also, list family members and their dates of birth if the information on the attached SF 2809 is not current. Complete the remainder of the information in this section if the information is not current or not included on the attached SF 2809.

7. NAME OF FAMILY MEMBERS	8. DATE OF BIRTH		
	MONTH	DAY	YEAR

9. Does this enrollee have insurance other than FEHB? ☐ No ☐ Yes. If yes, complete items 10 through 16.

10. NAME OF INSURANCE COMPANY

11. POLICYHOLDER'S SOCIAL SECURITY NUMBER

12. GROUP OR EMPLOYER NAME

13. NAME OF POLICYHOLDER

14. TYPE OF COVERAGE

☐ Self ☐ Self and Family

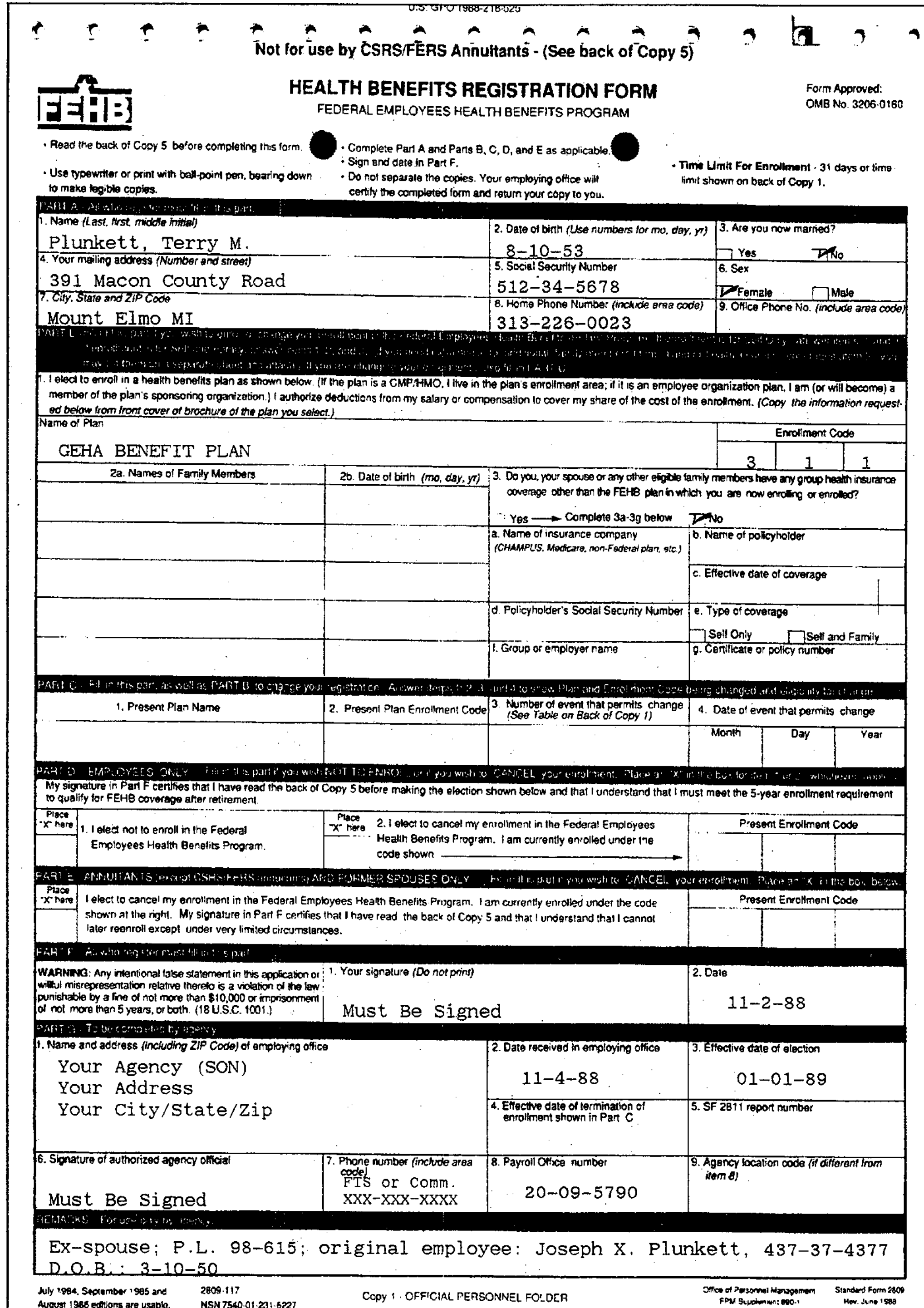
15. CERTIFICATE OR POLICY NUMBER

16. EFFECTIVE DATE OF COVERAGE

17. REMARKS

FORM DPRS-20 (1/90)

Billings and Collections Manual
Direct Premium Remittance System
Original SF-2809 for Enrollment



Not for use by CSRS/FERS Annuitants - (See back of Copy 5)

FEHB

HEALTH BENEFITS REGISTRATION FORM
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Form Approved: OMB No. 3206-0160

- Read the back of Copy 5 before completing this form.
- Use typewriter or print with ball-point pen, bearing down to make legible copies.
- Complete Part A and Parts B, C, D, and E as applicable.
- Sign and date in Part F.
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- Time Limit For Enrollment - 31 days or time limit shown on back of Copy 1.

PART A

1. Name (Last, first, middle initial)	2. Date of birth (Use numbers for mo, day, yr)	3. Are you now married?
Plunkett, Terry M.	8-10-53	Yes / No (X)
4. Your mailing address (Number and street)	5. Social Security Number	6. Sex
391 Macon County Road	512-34-5678	Female (X) / Male
7. City, State and ZIP Code	8. Home Phone Number (include area code)	9. Office Phone No. (include area code)
Mount Elmo MI	313-226-0023	

PART B

1. I elect to enroll in a health benefits plan as shown below. (If the plan is a CMP/HMO, I live in the plan's enrollment area; if it is an employee organization plan, I am (or will become) a member of the plan's sponsoring organization.) I authorize deductions from my salary or compensation to cover my share of the cost of the enrollment. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of Plan	Enrollment Code
GEHA BENEFIT PLAN	3 1 1

2a. Names of Family Members	2b. Date of birth (mo, day, yr)

3. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled?
Yes → Complete 3a-3g below / No (X)

a. Name of insurance company (CHAMPUS, Medicare, non-Federal plan, etc.)
b. Name of policyholder
c. Effective date of coverage
d. Policyholder's Social Security Number
e. Type of coverage: Self Only / Self and Family
f. Group or employer name
g. Certificate or policy number

PART C

1. Present Plan Name	2. Present Plan Enrollment Code	3. Number of event that permits change (See Table on Back of Copy 1)	4. Date of event that permits change: Month / Day / Year

PART D EMPLOYEES ONLY

My signature in Part F certifies that I have read the back of Copy 5 before making the election shown below and that I understand that I must meet the 5-year enrollment requirement to qualify for FEHB coverage after retirement.

Place "X" here — 1. I elect not to enroll in the Federal Employees Health Benefits Program.

Place "X" here — 2. I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown → Present Enrollment Code

PART E ANNUITANTS (except CSRS/FERS annuitants) AND FORMER SPOUSES ONLY

Place "X" here — I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right. My signature in Part F certifies that I have read the back of Copy 5 and that I understand that I cannot later reenroll except under very limited circumstances. — Present Enrollment Code

PART F

WARNING: Any intentional 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
Must Be Signed	11-2-88

PART G To be completed by agency

1. Name and address (including ZIP Code) of employing office	2. Date received in employing office	3. Effective date of election
Your Agency (SON) Your Address Your City/State/Zip	11-4-88	01-01-89
	4. Effective date of termination of enrollment shown in Part C	5. SF 2811 report number

6. Signature of authorized agency official	7. Phone number (include area code)	8. Payroll Office number	9. Agency location code (if different from item 8)
Must Be Signed	FTS or Comm. XXX-XXX-XXXX	20-09-5790	

REMARKS

Ex-spouse; P.L. 98-615; original employee: Joseph X. Plunkett, 437-37-4377 D.O.B.: 3-10-50

July 1984, September 1985 and August 1988 editions are usable. 2809-117 NSN 7540-01-231-5227 — Copy 1 - OFFICIAL PERSONNEL FOLDER — Office of Personnel Management FPM Supplement 890-1 — Standard Form 2809 Rev. June 1988

U.S. GOVERNMENT PRINTING OFFICE: 1987-193-167/60889

Federal Employees Health Benefits Program

Notice of Change in Health Benefits Enrollment

Part A—Identifying Data

1. Name (Last, first, middle initial)	2. Date of Birth	3. Social Security Number
4. Address (Including ZIP Code) 25 Mass Transfer Outs SSN 224-11-2345 through 511-12-5432	5. Payroll Office Number 20-09-5790	6. Enrollment Code Number 311
	7. SF 2811 Report No.	8. Date This Action Becomes Effective See Appendix 2 Part A-8

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form unless your enrollment is terminated and you apply for conversion.

Part B—Termination

☐ Your enrollment terminates on the date in Part A, item 8, above.

IMPORTANT NOTICE: YOU HAVE THE RIGHT TO CONVERT TO AN INDIVIDUAL CONTRACT WITH THE CARRIER OF YOUR PLAN. See **Part B—Termination** on the back of this form for information about your extension of coverage and conversion. If you want to convert, fill in the box on the back of this form and send it to your plan **within the time limit specified**.

Part C—Transfer Out

[X] This enrollment continues but is transferred to the new Payroll Office (or Retirement System) shown below. See Part C on the back of this form for more information.

USDA - National Finance Center
Direct Premium Remittance System

Part D—Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part I below has accepted transfer of this enrollment and will continue it.

Part E—Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part F—Change in Name of Enrollee

☐ The name in which this enrollment is carried has been changed to:

Name	Date of Birth
Address (Including ZIP Code) if different from Part A, item 4, above.	

Part G—Change in Enrollment—Survivor Annuitant

☐ Your enrollment has been changed from family coverage to Self Only. Your plan will send you a new identification card. Your new enrollment code number is shown below.
(NOTE: This item is completed by Retirement Systems only.)

New Enrollment Code Number →

Part H—Remarks

Part I—Date of Notice

(NOTE: Instructions for Employing Offices are on the back of Copy 4 of this form.)

Name of Agency and Address (Including ZIP Code)	
Your Agency (SON) Your Address Your City/State/Zip	
Signature of Authorized Agency Official: Must Be Signed Phone #	Date: 10-04-90

Office of Personnel Management
FPM Supplement 890-1
Previous editions not usable
NSN 7540-01-232-1234
2810-101
Copy 1 - To Enrollee
Standard Form 2810
Rev. January 1987

(reserved)

Forms for Corrections

U.S. GPO 1988-218-525

Not for use by CSRS/FERS Annuitants - (See back of Copy 5)

FEHB

HEALTH BENEFITS REGISTRATION FORM

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Form Approved: OMB No. 3206-0160

- Read the back of Copy 5 before completing this form.
- Use typewriter or print with ball-point pen, bearing down to make legible copies.
- Complete Part A and Parts B, C, D, and E as applicable.
- Sign and date in Part F.
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- Time Limit For Enrollment - 31 days or time limit shown on back of Copy 1.

PART A

Field	Entry
1. Name (Last, first, middle initial)	Hampton, Gary T.
2. Date of birth (Use numbers for mo, day, yr)	8-10-51
3. Are you now married?	Yes (checked) / No
4. Your mailing address (Number and street)	234 Montoya Ave.
5. Social Security Number	433-57-3321
6. Sex	Female / Male (checked)
7. City, State and ZIP Code	Monroe, LA 71234
8. Home Phone Number (include area code)	504-721-1546
9. Office Phone No. (include area code)	

PART B

1. I elect to enroll in a health benefits plan as shown below. (If the plan is a CMP/HMO, I live in the plan's enrollment area; if it is an employee organization plan, I am (or will become) a member of the plan's sponsoring organization.) I authorize deductions from my salary or compensation to cover my share of the cost of the enrollment. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of Plan	Enrollment Code		
Maxicare - Louisiana	J	A	2

2a. Names of Family Members	2b. Date of birth (mo, day, yr)
Karen Marie	11-30-52

3. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled?
Yes —► Complete 3a-3g below / No (checked)

a. Name of insurance company (CHAMPUS, Medicare, non-Federal plan, etc.)
b. Name of policyholder
d. Policyholder's Social Security No.
f. Group or employer name

Note:
Dependents must be listed again on the form for correction.

PART C

1. Present Plan Name	2. Present Plan Enrollment Code	3. Number of event that permits change (See Table on Back of Copy 1)	Month	Day	Year
Humana Medical - Plan	J H 2				

PART D — EMPLOYEES ONLY

My signature in Part F certifies that I have read the back of Copy 5 before making the election shown below and that I understand that I must meet the 5-year enrollment requirement to qualify for FEHB coverage after retirement.

Place "X" here — 1. I elect not to enroll in the Federal Employees Health Benefits Program.

Place "X" here — 2. I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown —► Present Enrollment Code

PART E — ANNUITANTS (except CSRS/FERS) AND FORMER SPOUSES ONLY

Place "X" here — I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right. My signature in Part F certifies that I have read the back of Copy 5 and that I understand that I cannot later reenroll except under very limited circumstances. — Present Enrollment Code

PART F

WARNING: Any intentional 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
Must Be Signed	10-20-90

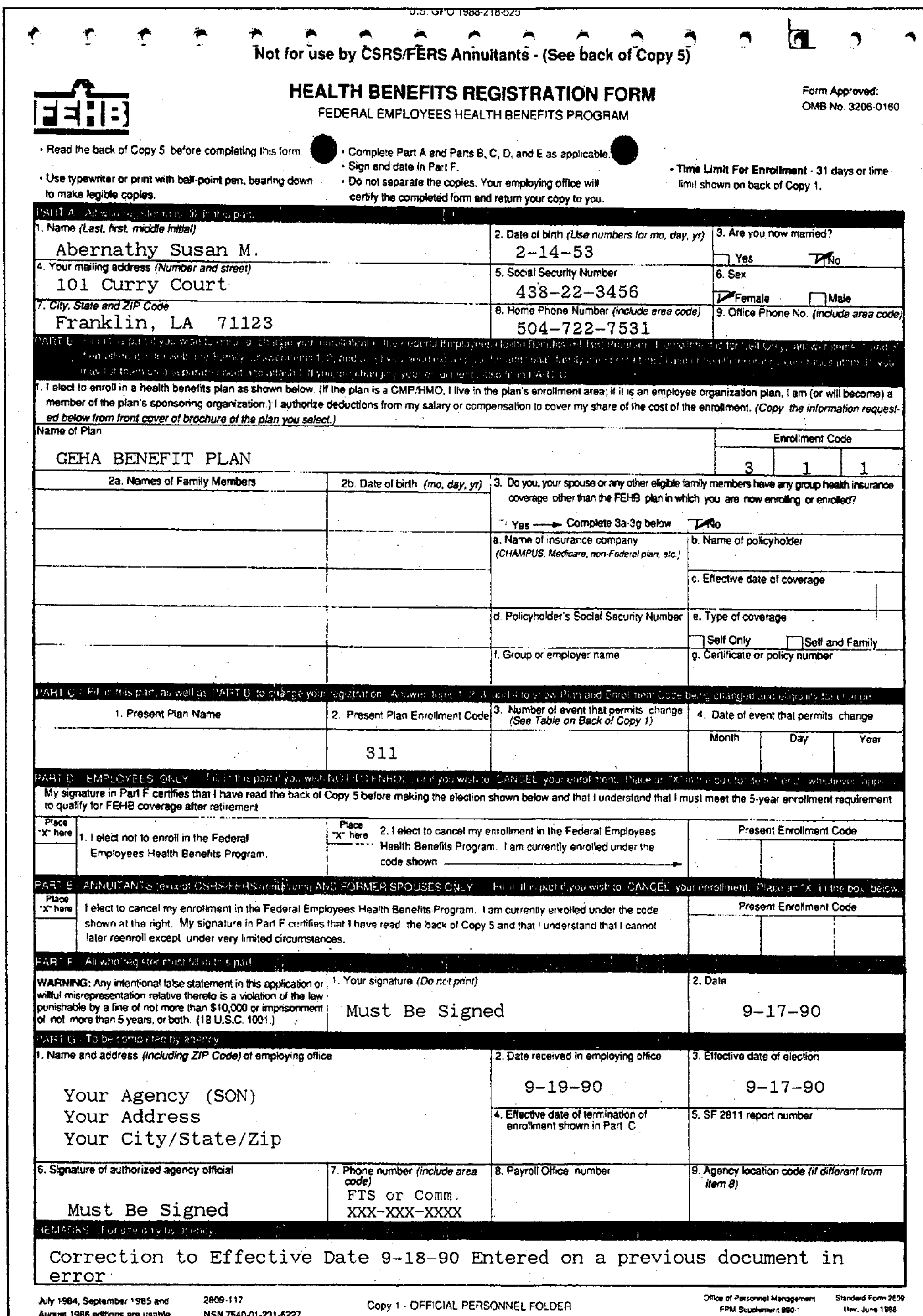
PART G — To be completed by agency

Field	Entry
1. Name and address (including ZIP Code) of employing office	Your Agency (SON) Your Address Tour City/State/Zip
2. Date received in employing office	10-22-90
3. Effective date of election	11-21-90
4. Effective date of termination of enrollment shown in Part C	
5. SF 2811 report number	
6. Signature of authorized agency official	Must Be Signed
7. Phone number (include area code)	FTS or Comm XXX-XXX-XXXX
8. Payroll Office number	
9. Agency location code (if different from item 8)	

REMARKS

Correction to enrollment code JH2, the enrollment code should be JA2.

July 1984, September 1985 and August 1986 editions are usable. 2809-117 NSN 7540-01-231-6227 Copy 1 - OFFICIAL PERSONNEL FOLDER Office of Personnel Management FPM Supplement 890-1 Standard Form 2809 Rev. June 1988



Not for use by CSRS/FERS Annuitants - (See back of Copy 5)

FEHB

HEALTH BENEFITS REGISTRATION FORM
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Form Approved: OMB No. 3206-0160

- Read the back of Copy 5 before completing this form.
- Use typewriter or print with ball-point pen, bearing down to make legible copies.
- Complete Part A and Parts B, C, D, and E as applicable.
- Sign and date in Part F.
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- Time Limit For Enrollment - 31 days or time limit shown on back of Copy 1.

PART A

1. Name (Last, first, middle initial): Abernathy Susan M.
2. Date of birth (Use numbers for mo, day, yr): 2-14-53
3. Are you now married? Yes / No [X No]
4. Your mailing address (Number and street): 101 Curry Court
5. Social Security Number: 438-22-3456
6. Sex: [X Female] Male
7. City, State and ZIP Code: Franklin, LA 71123
8. Home Phone Number (include area code): 504-722-7531
9. Office Phone No. (include area code):

PART B

1. I elect to enroll in a health benefits plan as shown below. (If the plan is a CMP/HMO, I live in the plan's enrollment area; if it is an employee organization plan, I am (or will become) a member of the plan's sponsoring organization.) I authorize deductions from my salary or compensation to cover my share of the cost of the enrollment. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of Plan: GEHA BENEFIT PLAN
Enrollment Code: 3 1 1

2a. Names of Family Members	2b. Date of birth (mo, day, yr)

3. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? Yes → Complete 3a-3g below [X No]

a. Name of insurance company (CHAMPUS, Medicare, non-Federal plan, etc.)
b. Name of policyholder
c. Effective date of coverage
d. Policyholder's Social Security Number
e. Type of coverage: Self Only / Self and Family
f. Group or employer name
g. Certificate or policy number

PART C

1. Present Plan Name	2. Present Plan Enrollment Code	3. Number of event that permits change (See Table on Back of Copy 1)	4. Date of event that permits change Month	Day	Year
	311				

PART D EMPLOYEES ONLY

My signature in Part F certifies that I have read the back of Copy 5 before making the election shown below and that I understand that I must meet the 5-year enrollment requirement to qualify for FEHB coverage after retirement.

Place "X" here: 1. I elect not to enroll in the Federal Employees Health Benefits Program.
Place "X" here: 2. I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown →
Present Enrollment Code

PART E ANNUITANTS (except CSRS/FERS annuitants) AND FORMER SPOUSES ONLY

Place "X" here: I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right. My signature in Part F certifies that I have read the back of Copy 5 and that I understand that I cannot later reenroll except under very limited circumstances.
Present Enrollment Code

PART F

WARNING: Any intentional 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): Must Be Signed
2. Date: 9-17-90

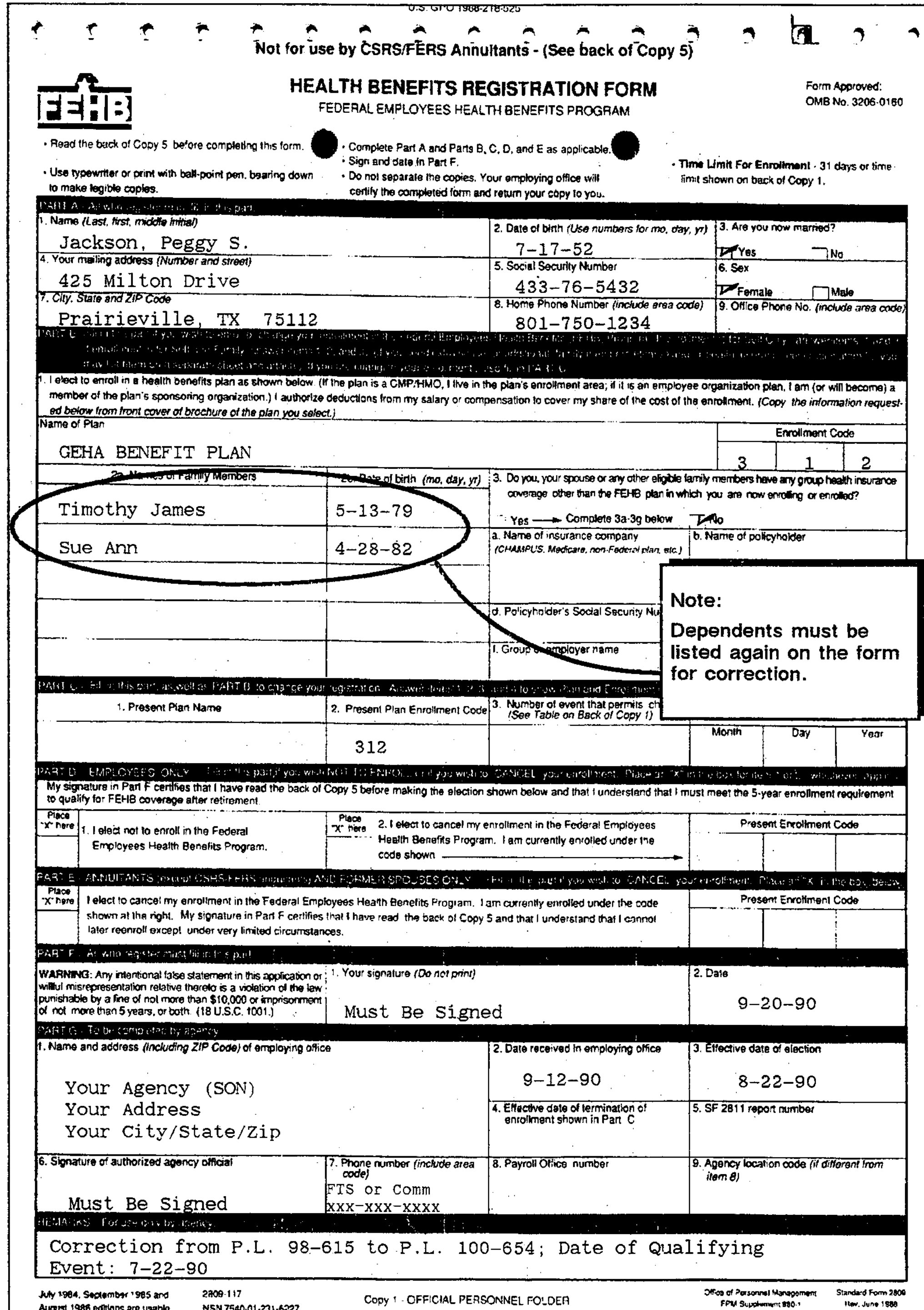
PART G To be completed by agency

1. Name and address (including ZIP Code) of employing office:
Your Agency (SON)
Your Address
Your City/State/Zip
2. Date received in employing office: 9-19-90
3. Effective date of election: 9-17-90
4. Effective date of termination of enrollment shown in Part C
5. SF 2811 report number
6. Signature of authorized agency official: Must Be Signed
7. Phone number (include area code): FTS or Comm. XXX-XXX-XXXX
8. Payroll Office number
9. Agency location code (if different from item 8)

REMARKS

Correction to Effective Date 9-18-90 Entered on a previous document in error

July 1984, September 1985 and August 1988 editions are usable. 2809-117 NSN 7540-01-231-5227
Copy 1 - OFFICIAL PERSONNEL FOLDER
Office of Personnel Management FPM Supplement 890-1
Standard Form 2809 Rev. June 1988



Not for use by CSRS/FERS Annuitants - (See back of Copy 5)

FEHB

HEALTH BENEFITS REGISTRATION FORM
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Form Approved:
OMB No. 3206-0160

- Read the back of Copy 5 before completing this form.
- Use typewriter or print with ball-point pen, bearing down to make legible copies.
- Complete Part A and Parts B, C, D, and E as applicable.
- Sign and date in Part F.
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- Time Limit For Enrollment - 31 days or time limit shown on back of Copy 1.

PART A

Field	Entry
1. Name (Last, first, middle initial)	Jackson, Peggy S.
2. Date of birth (Use numbers for mo, day, yr)	7-17-52
3. Are you now married?	Yes
4. Your mailing address (Number and street)	425 Milton Drive
5. Social Security Number	433-76-5432
6. Sex	Female
7. City, State and ZIP Code	Prairieville, TX 75112
8. Home Phone Number (include area code)	801-750-1234
9. Office Phone No. (include area code)	

PART B

1. I elect to enroll in a health benefits plan as shown below. (If the plan is a CMP/HMO, I live in the plan's enrollment area; if it is an employee organization plan, I am (or will become) a member of the plan's sponsoring organization.) I authorize deductions from my salary or compensation to cover my share of the cost of the enrollment. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of Plan	Enrollment Code
GEHA BENEFIT PLAN	3 1 2

2a. Names of Family Members	2b. Date of birth (mo, day, yr)
Timothy James	5-13-79
Sue Ann	4-28-82

3. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? Yes — Complete 3a-3g below; No (checked)

a. Name of insurance company (CHAMPUS, Medicare, non-Federal plan, etc.)
b. Name of policyholder
d. Policyholder's Social Security Number
f. Group or employer name

PART C

1. Present Plan Name	2. Present Plan Enrollment Code	3. Number of event that permits change (See Table on Back of Copy 1)	Month	Day	Year
	312				

PART D EMPLOYEES ONLY

My signature in Part F certifies that I have read the back of Copy 5 before making the election shown below and that I understand that I must meet the 5-year enrollment requirement to qualify for FEHB coverage after retirement.

Place "X" here — 1. I elect not to enroll in the Federal Employees Health Benefits Program.

Place "X" here — 2. I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown → Present Enrollment Code

PART E ANNUITANTS (except CSRS/FERS annuitants) AND FORMER SPOUSES ONLY

Place "X" here — I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right. My signature in Part F certifies that I have read the back of Copy 5 and that I understand that I cannot later reenroll except under very limited circumstances. Present Enrollment Code

PART F

WARNING: Any intentional 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
Must Be Signed	9-20-90

PART G To be completed by agency

Field	Entry
1. Name and address (including ZIP Code) of employing office	Your Agency (SON) Your Address Your City/State/Zip
2. Date received in employing office	9-12-90
3. Effective date of election	8-22-90
4. Effective date of termination of enrollment shown in Part C	
5. SF 2811 report number	
6. Signature of authorized agency official	Must Be Signed
7. Phone number (include area code)	FTS or Comm xxx-xxx-xxxx
8. Payroll Office number	
9. Agency location code (if different from item 8)	

REMARKS For use only by agency

Correction from P.L. 98-615 to P.L. 100-654; Date of Qualifying Event: 7-22-90

July 1984, September 1985 and August 1986 editions are usable. 2809-117 NSN 7540-01-231-6227 Copy 1 - OFFICIAL PERSONNEL FOLDER Office of Personnel Management FPM Supplement 890-1 Standard Form 2809 Rev. June 1988

Reports

Billings and Collections Manual
Direct Premium Remittance System
Report DPRS1501, Report of SF–2809's, 2810's Processed

REPORT NO. DPRS1501 | USDA/OFM/NFC | PAGE 001
DATE PREPARED 10/01/90 | DIRECT PREMIUM REMITTANCE SYSTEM
SUBMITTING OFFICE NO. 5317 | REPORT OF SF-2809'S, SF-2810'S PROCESSED
FOR THE MONTH OF SEPTEMBER

SSN	EMPLOYEE NAME	FEHB PLAN	ACTION TAKEN	----SF-2809/SF-2810 DATES---- RECEIVED	PROCESSED	EFFECTIVE	EVENT CODE	EXPIRE DATE	ADD	DEPT	RELATIONSHIP
437-64-1234	Smith, Michael T	104	ENR	09/04/90	09/08/90	09/28/90		08/27/93	D	AG	(CHILD)
438-22-2345	Abernathy, Susan M.	311	ENR	09/10/90	09/14/90	09/17/90		09/16/93	D	AG	(EX-SPOUSE)
442-11-2345	Adams, John Q.	YY2	ENR	08/28/90	09/02/90	09/03/90		03/03/92	D	AG	(SELF)
444-12-3345	James, Robert E.	452	ENR	09/21/90	09/28/90	09/24/90		09/23/93	D	AG	(EX-SPOUSE)
571-32-2211	Jackson, Peggy S.	312	ENR	09/04/90	09/12/90	09/22/90			D	AG	(SPOUSE EQUITY)
512-34-5678	Plunkett, Terry M.	311	TFI		09/05/90	09/07/90			D	AG	(SPOUSE EQUITY)
265-74-3894	Thomas, Vicki	105	COR	09/22/90	09/25/90	10/01/90			D	AG	(SPOUSE EQUITY)

ENR IS THE ABBREVIATION FOR ENROLLMENT
TFI IS THE ABBREVIATION FOR TRANSFER IN
COR IS THE ABBREVIATION FOR CORRECTION

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REPORT NO. DPRS1601                         USDA/OFM/NFC                                    PAGE 001
DATE PREPARED 10/01/90               DIRECT PREMIUM REMITTANCE SYSTEM
TIME PREPARED 09:14 AM       INDIVIDUAL RETIREMENT RECORD CHANGES FOR SPOUSE EQUITY
DEPT:NV SON: 2174                        09/16/90 TO 10/01/90

NOTE:  THIS REPORT SHOULD BE FORWARDED TO THE RETIREMENT SECTION OF THE PAYROLL OFFICE TO ANNOTATE ON THE ORIGINAL EMPLOYEES
       RETIREMENT MASTER RECORD (SF-2806/SF-3100) OR SUPPLEMENTAL RECORD (SF-2806-1/SF-3101) ANY SPOUSE EQUITY ENROLLMENTS,
       CANCELLATIONS, TERMINATIONS, OR REINSTATEMENTS IN ACCORDANCE WITH FPM SUPPLEMENT 890-1.  CHAPTER 17.

-----------------FORMER SPOUSE-----------    --------------ORIGINAL EMPLOYEE----------    EFFECTV    ACT
NAME               SSN          BIRTHDATE    NAME               SSN          BIRTHDATE    DATE       TKN

Thomas, Vicki      265743894    05/31/56     THOMAS, GEORGE     425-96-7415  10/10/41     10/01/90   ENR
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(reserved)

Appendixes

Instructions for Completion of SF–2809 and SF–2810

(reserved)

Block Number	Title	Type Of Data	Number Of Characters
Part A	All Who Register Must Fill In This Part.		
1	Name (Last, First, Middle Initial) **Entry:** Separated employee, child, or ex–spouse's name (last, first, and middle initial.)	Alpha/ numeric	20 – Last 15 – First 1 – Mid.
2	Date Of Birth (Use Numbers For Mo., Day, Yr.) **Entry:** Separated employee, child, or ex–spouse's date of birth (month, day, and year).	Numeric	6
3	Are You Now Married? **Entry:** Check the appropriate block.	Alpha	1
4	Enrollee's Mailing Address (Number And Street) **Entry:** Street or rural route of the separated employee, child, or ex–spouse's mailing address.	Alpha/ numeric	25
5	Social Security Number **Entry:** Separated employee, child, or ex–spouse's social security number.	Numeric	9

Block Number	Title	Type Of Data	Number Of Characters
6	Sex **Entry:** Check the appropriate block.	Alpha	1
7	City, State, And Zip Code **Entry:** City, state, and ZIP Code of the separated employee, child, or ex-spouse's mailing address.	Alpha/ numeric	20 - City 2 - State 5 - Zip Zip + 4 - 4
8	Home Phone Number (Include Area Code) **Entry:** The Separated employee, child, or ex-spouse's home telephone number.	Numeric	10
9	Office Phone No. (Include Area Code) **Entry:** The separated employee, child, or ex-spouse's office telephone number or **daytime** telephone number where he/she can be reached	Numeric	10

Block Number	Title	Type Of Data	Number Of Characters
Part B	Fill In This Part If You Wish To Enroll Or Change Your Enrollment In The Federal Employees Health Benefits (FEHB) Program.		
1	Name Of Plan	Alpha/ numeric	35
	Enrollment Code	Alpha/ numeric	3
	Entry: The elected health benefits plan name and 3–digit enrollment code.		
2a/b	Name Of Family Members	Alpha/ numeric	35
	Date of Birth (Month, Day, Year	Numeric	6
	Entry: List all eligible family members and their birth dates. **Spouse must be listed first.**		
	Note: Any subsequent documents pertaining to enrollment into the Direct Premium Remittance System (DPRS), including corrections, should list **all** eligible family members and their birth dates again.		
3	Do You, Your Spouse, Or Another Eligible Family Members Have Any Group Health Insurance Coverage Other Than The FEHB Plan In Which You Are Now Enrolling Or Enrolled?	Alpha/ numeric	1
	Entry: Check the appropriate block. If "yes" is marked, complete Blocks 3a through 3g.		
3a	Name Of Insurance Company	Alpha/ numeric	35
	Entry: Name of the insurance company that the eligible family member has the other health insurance coverage with.		

Block Number	Title	Type Of Data	Number Of Characters
3b	Name Of Policyholder **Entry:** Name of the family member who is covered under another health plan.	Alpha/ numeric	35
3c	Effective Date Of Coverage **Entry:** The effective date of the coverage for the other health plan (month, day, and year).	Numeric	6
3d	Policyholder's Social Security Number **Entry:** The social security number of the eligible family member who is enrolled in another health plan.	Numeric	9
3e	Type Of Coverage **Entry:** The type of coverage of the other health plan. Check the appropriate block.	Alpha	1
3f	Group Or Employer Name **Entry:** The name of the group or employer that sponsors the other health plan.	Alpha/ numeric	35
3g	Certificate Or Policy Number **Entry:** The certificate or policy number of the other health plan.	Alpha/ numeric	35

Block Number	Title	Type Of Data	Number Of Characters
Part C	Fill In This Part As Well As Part B To Change Your Registration.		
1	Present Plan Name **Entry:** The name of the plan that the Separated employee, child, or ex–spouse is currently enrolled in.	Alpha	35
2	Present Plan Enrollment Code **Entry:** The enrollment code for the plan that the Separated employee, child, or ex–spouse is currently enrolled in.	Alpha/ numeric	3
3	Number Of Event That Permits Change **Entry:** The appropriate code that reflects the event that permits enrollment or change. **Code** — **Event** **01** — Open Season. **02** — Change in marital status. (Marriage, divorce, annulment, death of spouse.) **03** — Other change in family status (For example, birth of a child, legal separation, discharge from military service of a spouse or of a child under age 22.) **04** — Move from an area served by a pre–paid plan (CMP/HMO) in which enrolled at time of move. **05** — Termination of enrollment by employee organization plan because of termination of membership in organization. **10** — Your plan stops participating in the FEHB Program. **14** — You become eligible for Medicare **15** — Your eligible child (or children) loses coverage under another FEHB enrollment	Numeric	2
4	Date of Event that Permits Change **Entry:** Effective date of the change being made (month, day, year)	Numeric	6

Block Number	Title	Type Of Data	Number Of Characters
Part D	Employees Only		
1	I elect not to enroll in the Federal Employees Health Benefits Program **Entry: Not applicable** to DPRS enrollees. **Do Not Complete.**		
2	I Elect To Cancel My Present Enrollment In The Federal Employees Health Benefits program. I Am Currently Enrolled Under The Code Shown At The Right. **Entry:** Place an "X" in the box if the enrollee wishes to cancel coverage.	Alpha	1
	Present Enrollment Code **Entry:** Enrollment code the enrollee elects to cancel.	Alpha/ numeric	3

Block Number	**Title**	**Type Of Data**	**Number Of Characters**
Part E	Annuitants (*Except* CSRS/FERS Annuitants) And Former Spouses Only. Not applicable to DPRS enrollees. Use Part D for DPRS enrollee cancellations.		
Part F	All Who Register Must Fill In This Part		
1	Your Signature (Do Not Print) **Entry:** Enrollee's signature.	Alpha/ numeric	Unlimited
2	Date **Entry:** Date the Enrollee signed the SF–2809 (month, day, and year).	Numeric	6

Block Number	Title	Type Of Data	Number Of Characters
Part G	To Be Completed By Agency		
1	Name And Address (Including ZIP Code) Of Employing Office	Alpha/ numeric	Unlimited
	Entry: Name and address of the agency employing office.		
	Note: The Submitting Office Number (SON), also called the Employing Office Number and Personnel Office Identifier (POI) **must be included in this block** to process the SF–2809 in DPRS.	Alpha/ numeric	4
2	Date Received In Employing Office	Numeric	6
	Entry: Date the SF–2809 was received in the agency employing office (month, day, and year).		
3	Effective Date Of Election	Numeric	6
	Entry: Effective date of coverage (month, day, and year).		
	Note: The effective date of election is the 32nd day after the last day of the pay period or pay cycle in which the employee separates (separated employee only).		
	▶ **The effective date of election is the 31st day after the date of qualifying event for former spouse and child under TCC.**		
	For former spouse under P.L. 98–651, see FPM Supplement 890–1, Subchapter S17–8. ◀		
4	Effective Date Of Termination Of Enrollment Shown In Part C.	Numeric	6
	Entry: Effective date the coverage was terminated (month, day, and year).		

Block Number	Title	Type Of Data	Number Of Characters
5	SF 2811 Report Number **Entry:** **Do not complete.** The SF–2811 report number will be generated by NFC.		
6	Signature Of Authorized Agency Official **Entry:** Signature of the authorized agency official. **Note:** If the document is not signed, it will be returned.	Alpha/ numeric	Unlimited
7	Phone Number (Include Area Code) **Entry:** The telephone number of the authorized agency official completing the form.	Numeric	10
8	Payroll Office Number **Entry:** Payroll Office Number (For Post Office: Appropriate Finance Management Number.)	Numeric	8
9	Agency Location Code (If Different From Item 8) **Entry:** The agency location code.	Alpha/ numeric	(Unlimited)

Block Number	Title	Type Of Data	Number Of Characters
Remarks	Remarks *(For Use By Agency Only)*	Alpha/ numeric	4 lines at 39 characters each

Entry: The following information **must** be entered in the Remarks block in the same order shown as appropriate for the class of enrollee:

Separated employee:

- Relationship (Self)
- The public law under which the applicant is eligible, using the law's whole number; i.e., P.L. 100-654 (5 USC 8905a).
- Date of separation (MM/DD/YY)
- Last day of pay period (MM/DD/YY)

Former spouse and child of a current employee:

- Relationship (ex-spouse, child)
- The Public Law under which the applicant is eligible for benefits, using the law's whole number; i.e., P.L. 98-615 or P.L. 100-654 (5 USC 8905a).
- Name of the employee
- Social security number of the employee
- Date of birth of the employee (MM/DD/YY)
- Date of the qualifying event; e.g., the date of divorce, annulment, or loss of coverage (Former Spouse - P.L. 100-654 only); or the Qualifying Date is the date of the event causing loss of coverage (e.g., date of a child's 22nd birthday, marriage, etc.). (MM/DD/YY)

Former spouse and child of a separated employee:

- Persons in this category should contact NFC directly for enrollment information.

Former spouse and child of Civil Service Retirement System (CSRS), Federal Employees Retirement System (FERS), or other retirement systems' annuitants:

- The Office of Personnel Management (OPM) or the appropriate retirement system will continue to process any accounts for annuitants' children or former spouses. Forms for these individuals should be sent to OPM or the appropriate retirement system, not to NFC.

Block Number	Title	Type Of Data	Number Of Characters
Part A	Identifying Data		
1	Name	Alpha/ numeric	20 - Last 15 - First 1 - Mid.

Entry: Separated employee, child, or ex-spouse's name (last, first, and middle initial).

For Mass Transfer Outs, leave the field blank.

Block Number	Title	Type Of Data	Number Of Characters
2	Date Of Birth	Numeric	6

Entry: Separated employee, child, or ex-spouse's date of birth (month, day, year).

For Mass Transfer Outs, leave the field blank.

Block Number	Title	Type Of Data	Number Of Characters
3	Social Security No.	Numeric	9

Entry: Separated employee, child, or ex-spouse's 9-digit social security number.

For Mass Transfer Outs, leave the field blank.

Block Number	Title	Type Of Data	Number Of Characters
4	Address (Including Zip Code)	Alpha/ numeric	35 - Street 20 - City 2 - State 5 - Zip

Entry: Separated employee, child, or ex-spouse's current address, including ZIP code.

For Mass Transfer Outs, enter the following information:
Total Number of Enrollees transfering out)
Mass Transfer Outs SSN XXX-XX-XXXX through XXX-XX-XXXX

Block Number	Title	Type Of Data	Number Of Characters
5	Payroll Office No.	Numeric	8

Entry: Eight digit payroll office number.

(For Post Office: Appropriate Finance Management Number.)

Block Number	Title	Type Of Data	Number Of Characters
6	Enrollment Code No.	Alpha/ numeric	3

Entry: Three-digit enrollment code.

Mass Transfer Outs can only be done by carrier and option code. If an employing office is transferring, for example, health plan code 311 and 312, a separate Transfer Out will have to be filled out for each code, even though both options are for the same carrier.

7	SF-2811 Report No.	Numeric	4

Entry: **Do Not Complete This Block.** This number will be entered by NFC.

8	Date This Action Becomes Effective	Numeric	6

Entry: Effective date of change (month, day, year).
Date enrollee paid through on your system. This will be the **Transfer Out Date.** Enrollees **must be current** in your system at time of transfer.

The date must be the same for all transfer out enrollees included on the **same** SF-2810.

Part B	Termination	Alpha	1

Entry: **Do not complete.** NFC will process any terminations for DPRS.

Part C	Transfer Out	Alpha	1

Entry: Check this block to transfer enrollment to DPRS. Also, enter "USDA National Finance Center Direct Premium Remittance System (DPRS)" in this block.

Part D	Transfer In	Alpha	1

Entry: **Do not complete.** NFC will process the Transfer In for temporary continuation and spouse equity enrollees.

Block Number	Title	Type Of Data	Number Of Characters
Part E	Reinstatement	Alpha	1

Entry: Do not complete. NFC will process any reinstatements.

Part F	Change In Name Of Enrollee		

Entry: Do not complete. The enrollee will contact NFC directly.

Part G	Change In Enrollment – Survivor Annuitant	Alpha	1

Entry: Do not complete. Not applicable to the temporary continuation or spouse equity enrollee.

Part H	Remarks	Alpha/ numeric	Unlimited

Entry: The appropriate remarks. Also, please enter **the name and telephone number of the person completing this form** in the Remarks block.

Example: (Form Completed by: Jane Doe)
Telephone No. (123) 456–7890

Part I	Date Of Notice		
	Name Of Agency And Address, Including Zip Code	Alpha/ numeric	Unlimited

Entry: The name and address of the employing office.

	Signature Of Authorized Agency Official	Alpha/ numeric	Unlimited

Entry: This block must be completed by the **authorized** agency official only.

	Date (month, day, and year)	Numeric	6

Entry: Enter the date signed by the authorized official.

Note: If the document is not signed, it will be returned.

(reserved)