



## 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 <input type="checkbox"/> M <input type="checkbox"/> F	5. Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Home mailing address (including ZIP Code)		7. Medicare (See note - page 2) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		8. TRICARE <input type="checkbox"/>	9. Other insurance <input type="checkbox"/>
		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 <input type="checkbox"/> M <input type="checkbox"/> F	16. Relationship code
17. Address (if different from enrollee)		18. Medicare (See note - page 2) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		19. TRICARE <input type="checkbox"/>	20. Other insurance <input type="checkbox"/>
		21. Name of insurance		22. Insurance policy no.	
Name of family member (last, first, middle initial)		Social Security number	Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship code
Address (if different from enrollee)		Medicare (See note - page 2) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		TRICARE <input type="checkbox"/>	Other insurance <input type="checkbox"/>
		Name of insurance		Insurance policy no.	
Name of family member (last, first, middle initial)		Social Security number	Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship code
Address (if different from enrollee)		Medicare (See note - page 2) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		TRICARE <input type="checkbox"/>	Other insurance <input type="checkbox"/>
		Name of insurance		Insurance policy no.	
Name of family member (last, first, middle initial)		Social Security number	Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship code
Address (if different from enrollee)		Medicare (See note - page 2) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		TRICARE <input type="checkbox"/>	Other insurance <input type="checkbox"/>
		Name of insurance		Insurance policy no.	

<b>Part B - Present Plan</b>		<b>Part C - New Plan</b>	
1. Plan name	2. Enrollment code	1. Plan name	2. Enrollment code

<b>Part D - Event Code</b>		<b>Part E - Employees Only (Election NOT to Enroll)</b>	
1. Event code	2. Date of event	<input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	

<b>Part F - Cancellation</b>		<b>Part G - Suspension (Annuitants/Formers/Spouses Only)</b>	
<input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		<input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	

**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
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**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	