



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 (mm/dd/yyyy)	4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	5. Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No
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6. Home mailing address (including ZIP Code)	7. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	8. Medicare Beneficiary Identifier
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9. Are you covered by insurance other than Medicare?
 Yes, indicate in item 10 below. No

10. Indicate the type(s) of other insurance:
 TRICARE Other Name of other insurance: _____ Policy Number: _____
 FEHB An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.

11. Email address	12. Preferred telephone number
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13. Name of family member (last, first, middle initial)	14. Social Security Number	15. Date of birth (mm/dd/yyyy)	16. Sex <input type="checkbox"/> M <input type="checkbox"/> F	17. Relationship code
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18. Address (if different from enrollee)	19. If this family member is covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	20. Medicare Beneficiary Identifier
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21. Is this family member covered by insurance other than Medicare?
 Yes, indicate in item 22 below. No

22. Indicate the type(s) of other insurance:
 TRICARE Other Name of other insurance: _____ Policy Number: _____
 FEHB An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.

23. Email address (if applicable, enter email address of your spouse or adult child)	24. Preferred telephone number (if applicable, enter preferred phone number of your spouse or adult child)
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25. Name of family member (last, first, middle initial)	26. Social Security Number	27. Date of birth (mm/dd/yyyy)	28. Sex <input type="checkbox"/> M <input type="checkbox"/> F	29. Relationship code
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30. Address (if different from enrollee)	31. If this family member is covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	32. Medicare Beneficiary Identifier
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33. Is this family member covered by insurance other than Medicare?
 Yes, indicate in item 34 below. No

34. Indicate the type(s) of other insurance:
 TRICARE Other Name of other insurance: _____ Policy Number: _____
 FEHB An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.

35. Email address (if applicable, enter email address of your spouse or adult child)	36. Preferred telephone number (if applicable, enter preferred phone number of your spouse or adult child)
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37. Name of family member (last, first, middle initial)	38. Social Security Number	39. Date of birth (mm/dd/yyyy)	40. Sex <input type="checkbox"/> M <input type="checkbox"/> F	41. Relationship code
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42. Address (if different from enrollee)	43. If this family member is covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	44. Medicare Beneficiary Identifier
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45. Is this family member covered by insurance other than Medicare?
 Yes, indicate in item 46 below. No

46. Indicate the type(s) of other insurance:
 TRICARE Other Name of other insurance: _____ Policy Number: _____
 FEHB An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.

47. Email address (if applicable, enter email address of your spouse or adult child)	48. Preferred telephone number (if applicable, enter preferred phone number of your spouse or adult child)
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(Continued on the reverse)

Enrollee name: _____ Date of birth: _____

Part B - FEHB Plan You Are Currently Enrolled In (if applicable)		Part C - FEHB Plan You Are Enrolling In or Changing To	
1. Plan name	2. Enrollment code	1. Plan name	2. Enrollment code

Part D - Event That Permits You To Enroll, Change, or Cancel (see page 6)		Part E - Election NOT to Enroll (Employees Only)	
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>
2A	11/09/2020		

Part F - Cancellation of FEHB		Part G - Suspension of FEHB (Annuitants/Former Spouses Only)	
<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)
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Part I - To be completed by agency or retirement system
REMARKS

1. Date received (mm/dd/yyyy)	2. Effective date of action (mm/dd/yyyy) 01/01/2020	3. Personnel telephone number (866) 300-7419
4. Name and address of agency or retirement system		5. Authorizing official (please print)
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7. Payroll office number 19-00-0001	8. Payroll office contact (please print) Payroll Customer Support	9. Payroll telephone number (877) 865-0760

PRINT **SAVE** **CLEAR**

INSTRUCTIONS FOR COMPLETING THE SF 2809

Part A — Enrollee and Family Member Information.

- Item 5. If you are separated but not divorced, you are still married.
- Item 7. If you have Medicare, show which Parts you have. Also indicate whether you have prescription drug coverage under the Medicare Part D program.
- Item 9. If you have other group insurance (private, state, Medicaid, CHAMPVA), check the box.
- Item 10. Check the appropriate block. If other, write the name of any other insurance you have. 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.
- Items 13, 25, 37. Complete information for family members **only if your enrollment is for Self Plus One or Self and Family**. (If you need extra space for additional family members, list them on a separate sheet and attach.) If a family member has Medicare, show which parts he/she has on the line with his/her name.
- Item 17, 29, 41. Provide the code which indicates the relationship of each eligible family member to you.

CODE	Family Relationship
01	Spouse
19	Child under age 26
09	Adopted Child under age 26
17	Stepchild under age 26
10	Foster Child under age 26
99	Disabled child age 26 or older incapable of self-support because of a physical or mental disability that began before age 26.

Part F — Cancellation of FEHB.

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. The HR Service Center 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.

Part G — Suspension.

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 or
- ◆ Peace Corps

You can re-enroll 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 HR Service Center with your SF-2809.