SAMPLE OF A COMPLETED OPEN SEASON ELECTION FORM

Form Approved:
OMB No. 3206-0160

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	5. Are you married?
Chutney, Mango	900-90-9000	01/02/0345	☐ M ☑ F	☒ Yes ☐ No

6. Home mailing address *(including ZIP Code)*	7. If you are covered by Medicare, check all that apply.	8. Medicare Beneficiary Identifier
123 Pineapple Way Peach Citv. KS 99979	☐ A ☐ B ☐ D	

9. Are you covered by insurance other than Medicare? Response required
☑ Yes, indicate in item 10 below. 10. ☐ No

Indicate the type(s) of other insurance: Only list insurance you will carry in addition to this FEHB election.

☐ TRICARE ☒ Other *Name of other insurance:* Coconut Coverage High Option *Policy Number:* 9876543210

☐ 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
mango.chutney@fakemail.com	(104) 784-5240

13. Name of family member *(last, first, middle initial)*	14. Social Security Number	15. Date of birth *(mm/dd/yyyy)*	16. Sex	17. Relationship code
Chutney, Pear	800-80-8000	03/04/0567	☒ M ☐ F	See page 2 for list of codes 19

18. Address *(if different from enrollee)*	19. If this family member is covered by Medicare, check all that apply.	20. Medicare Beneficiary Identifier
	☐ A ☐ B ☐ D	

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)*

25. Name of family member *(last, first, middle initial)*	26. Social Security Number	27. Date of birth *(mm/dd/yyyy)*	28. Sex	29. Relationship code
Chutney, Tomato	700-70-7000	02/03/6789	☐ M ☑ F	01

30. Address *(if different from enrollee)*	31. If this family member is covered by Medicare, check all that apply.	32. Medicare Beneficiary Identifier
	☐ A ☐ B ☐ D	

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)*

37. Name of family member *(last, first, middle initial)*	38. Social Security Number	39. Date of birth *(mm/dd/yyyy)*	40. Sex	41. Relationship code
			☐ M ☐ F	

42. Address *(if different from enrollee)*	43. If this family member is covered by Medicare, check all that apply.	44. Medicare Beneficiary Identifier
	☐ A ☐ B ☐ D	

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)*

(Continued on the reverse)

Enrollee name: Chutney, Mango Date of birth: 01/02/0345

Look for enrollment codes on the OPM website. They can also be found on the cover page of the plan brochure.

Part B - FEHB Plan You Are Currently Enrolled In *(if applicable)*

1. Plan name	2. Enrollment code
Orange Coverage	ABC

Part C - FEHB Plan You Are Enrolling In or Changing To

1. Plan name	2. Enrollment code
Grape Coverage Low Option	DEF

Part D - Event That Permits You To Enroll, Change, or Cancel *(see page 6)*

1. Event code	2. Date of event
Use1B for Open Season Elections: 1B	First day Of Open Season: 11/11/2024

Part E - Election NOT to Enroll *(Employees Only)*

☐ I do NOT want to enroll in the FEHB Program.
My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.

Part F - Cancellation of FEHB

☐ I CANCEL my enrollment.
My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.

Part G - Suspension of FEHB *(Annuitants/Former Spouses Only)*

☐ I SUSPEND my enrollment.
My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.

Part H - Signature

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*	2. Date *(mm/dd/yyyy)*
REMEMBER TO SIGN — Date must be the date you completed the form.	11/13/2024

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)*	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 ( )

*Once form has been completed, either email it to APHIS.Open.Season@usda.gov or fax it to 612-336-3501. Be sure to keep the fax confirmation sheet for your records

*Be sure to use the current version of the SF 2809, November 2019. Outdated versions will not be accepted.