FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

FEHB

OPEN SEASON
DPRS-2809
OMB 0505-0024
(Revised 10/15)

Read the enclosed instructions before completing this form. Return this form to:
USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161
You may fax your form to 303-274-3805.
Do not take any action to maintain your present coverage.

COMPLETE THIS FORM *ONLY* IF YOU ARE MAKING CHANGES.

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at **www.opm.gov/insure/health**.

SECTION I - 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 ☐ M ☐ F	5. ARE YOU MARRIED? ☐ YES ☐ NO
6. HOME MAILING ADDRESS *(including ZIP Code)*	☐ I need to correct my address. The changes are indicated in item 6	7. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D		8. MEDICARE CLAIM NUMBER
		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 ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.*		NAME OF OTHER INSURANCE		POLICY NUMBER

Dependents' Information. Fill in the applicable information in the blocks below. For additional family members please use a separate sheet of paper. Relationship Codes are: 01. Spouse; 19. Child under age 26; 09. Adopted child; 17. Step child; 10. Eligible foster child; 99. Disabled child age 26 or older who is incapable of self-support because of a physical or mental disability that began before his/her 26th birthday.

11. NAME OF FAMILY MEMBER *(last, first, middle initial)*	12. SOCIAL SECURITY NUMBER	13. DATE OF BIRTH *(mm/dd/yyyy)*	14. SEX ☐ M ☐ F	15. RELATIONSHIP CODE
16. ADDRESS *(if different from enrollee)*		17. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D		18. MEDICARE CLAIM NUMBER
		19. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 20 below. ☐ NO		
20. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.*		NAME OF OTHER INSURANCE		POLICY NUMBER
21. EMAIL ADDRESS *(if home address is different from enrollee's)*	22. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)*			

23. NAME OF FAMILY MEMBER *(last, first, middle initial)*	24. SOCIAL SECURITY NUMBER	25. DATE OF BIRTH *(mm/dd/yyyy)*	26. SEX ☐ M ☐ F	27. RELATIONSHIP CODE
28. ADDRESS *(if different from enrollee)*		29. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D		30. MEDICARE CLAIM NUMBER
		31. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 32 below. ☐ NO		
32. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.*		NAME OF OTHER INSURANCE		POLICY NUMBER
33. EMAIL ADDRESS *(if home address is different from enrollee's)*	34. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)*			

SECTION II - FEHB Plan You Are Currently Enrolled In

1. PLAN NAME	2. ENROLLMENT CODE

Section III - FEHB Plan You Are Changing to

1. PLAN NAME	2. ENROLLMENT CODE

SECTION IV - 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. EMAIL ADDRESS	4. PREFERRED TELEPHONE NUMBER ( )