HEALTH BENEFITS REGISTRATION FORM

Federal Employees Health Benefits Program

Form Approved:
OMB No. 3206-0160

- Complete Part A and Parts B, C, D, and E as applicable.
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- Type or Print Firmly.
- Sign and date in Part F.

PART A - *Fill in this part.*

1. Name *(Last, first, middle initial)*	2. Social Security number	3. Date of birth *(mo., day, yr.)* / /
4. Your home mailing address *(include ZIP code)*	5. Sex ☐ Male ☐ Female	6. Are you now married? ☐ Yes ☐ No
	7. Daytime telephone number ( )	

PART B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of plan	Enrollment code ▶			

2a. Names of family members	2b. ZIP code	2c. Date of birth *(mo., day, yr.)*	2d. Sex	2e. Relationship "code"	2f. Social Security number *(See Instructions)*
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			

3a. 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? ☐ No ☐ Yes ——▶ Complete 3b

3b. Type of insurance ▶ Medicare ☐ No ☐ Yes ——▶ *Indicate part(s)* ☐ CHAMPUS ☐ Other private *(specify name)*

PART C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name	2. Present Plan enrollment code ▶				3. Number of event that permits change *(See Table of Permissable Changes)*		4. Date of event that permits change *(mo., day, yr.)* / /

PART D - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART F certifies that I have read and understand the information regarding this election.

PART E - *CANCELLATION*

Place an "X" in the box below if you wish to CANCEL your enrollment.

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right.

Present Plan enrollment code		

My signature in PART F certifies that I have read the information in the instructions regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

PART F - *Fill in this part.*

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

PART G - *To be completed by agency*

1. Name and address of employing office

U.S. House of Representatives
Members' Services / FO
HB 1, The Capitol
Washington, DC 20515

2. Date received in employing office	3. Effective date of action	4. SF 2811 report number
5. Payroll office number 00 00 4831	6. Payroll contact and telephone number ( )	
7. Personnel contact and telephone number ( )		
8. Signature of authorized agency official	9. Phone number ( )	

Remarks