| 1. Name (Last, first, middle initial) | 2. Social Security number | 3. Date of birth (mo., day, yr.) |
|---|---|---|
| DOE, JOHN L | 111-11-1111 | 01 / 01 / 60 |
| **4. Your home mailing address (include ZIP code)** | **5. Sex** | **6. Are you now married?** |
| 123 MAIN STREET<br>ANYTOWN, XX 00000-0000 | XX Male ☐ Female | X Yes ☐ No |
| | **7. Daytime telephone number** | ( 000 ) 000-0000 |

**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: XXX Hospital Plan — Enrollment code: X 1 X

| 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) |
|---|---|---|---|---|---|
| JANE M DOE | 00000 | 12/12/60 | F | 1=spouse | 999-99-9999 |
| | | / / | | 2=child<br>3=step/foster/recognized child | |
| | | / / | | 4=unmarried/disabled child over 22 years incapable of self-support | |
| | | / / | | | |
| | | / / | | | |

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 |
|---|---|
| | 01/03/97 |

**PART G - *To be completed by agency***

1. Name and address of employing office

**Human Resources**
**Office of Personnel and Benefits**
**U.S. House of Representatives**
**263 Cannon HOB**
**Washington, DC 20515-6610**

| 2. Date received in employing office | 3. Effective date of action | 4. SF 2811 report number |
|---|---|---|
| | | |

| 5. Payroll office number | 6. Payroll contact and telephone number |
|---|---|
| 00004832 | ( 202 ) 225-6514 |

| 7. Personnel contact and telephone number | |
|---|---|
| Estelle M. Jones | ( 202 ) 225-6514 |

| 8. Signature of authorized agency official | 9. Phone number |
|---|---|
| | ( 202 ) 225-6514 |

**Remarks**