



Health Benefits Registration Form

Instructions for Completing OPM Form 2809
Type or Print Firmly.

Part A. You must complete this part.

- Item 1. Give your last name, first name and middle initial.
- Item 2. Enter your Social Security Number. (See the Privacy Act and Public Burden Statements on page 2.)
- Item 3. Give your date of birth, using numbers to show the month, day, and year, for example, *06/30/1998*.
- Item 4. Enter the mailing address you want us to use for all correspondence we send you.
- Item 5. Place an "X" in the appropriate box.
- Item 6. Place an "X" in the box that signifies your current marital status (if you are separated but not divorced, you are still married).
- Item 7. Give the telephone number where you can be reached during normal business hours. Be sure to include the area code.

Part B. Complete this part to enroll or change your enrollment in the FEHB Program.

- Item 1. Enter the plan name and appropriate enrollment code from the front cover of the brochure of the plan you want to enroll in or change to. The enrollment code shows the plan and option you are electing and whether you are enrolling for Self Only or Self and Family.

If the plan you want is a prepaid Health Maintenance Organization [HMO], be sure you live in the plan's enrollment area. If it is an employee organization plan, be sure you are eligible to enroll in the plan; you must be or become a member of the plan's sponsoring organization.

Family Members Eligible for Coverage

- ❖ Unless you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment include your spouse and your unmarried dependent children under age 22. Eligible children include your legitimate or adopted children; and, if they live in a regular parent-child relationship with you, recognized children born out of wedlock, stepchildren or foster children. A recognized child born out of wedlock also may be included if a judicial determination of support has been obtained or you show that you provide regular and substantial support for the child.

Other relatives (for example, your parents) are not eligible for coverage even if they live with you and are dependent upon you.

- ❖ If you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment are the unmarried dependent natural or adopted children under age 22 of both you and your former or deceased spouse.
- ❖ Children whose marriage ends before they reach age 22 become eligible for coverage under your Self and Family enrollment from the date the marriage ends until they reach age 22.
- ❖ In some cases, an unmarried, disabled child who is over age 22 is eligible for coverage under your Self and Family enrollment if you provide adequate medical certification of a mental or physical disability that existed before his or her 22nd birthday that renders the child incapable of self-support.

Item 2a. Indicate the full name of each covered family member.

Item 2b. Provide the ZIP code if it is different from the enrollee's ZIP code in Part A, item 4.

Item 2c. Provide the family member's date of birth, using numbers to show the month, day, and year.

Item 2d. Indicate M for male or F for female.

Item 2e. Provide the code which indicates the relationship of the eligible family member to you.

1. Spouse
2. Unmarried dependent child under age 22 (including an adopted child)
3. Stepchild, foster child or recognized natural child
4. Unmarried disabled child over age 22 incapable of self-support.

Item 2f. Enter the family member's social security number. (See the Privacy Act and Public Burden Statements on page 2.)

Item 3a. Place an "X" in the appropriate box. If you answer "Yes," enter the name of the policyholder in the space provided and complete item 3b.

Item 3b. If you or your spouse have Medicare, check the Medicare box and show which Parts each of you have.

If you or any covered family member have CHAMPVA, TRICARE, or TRICARE for Life, check that box.

If you or any covered family member have any other group insurance, check that box and give the name of the insurance company.

Part C. You must complete this part if you are changing your enrollment.

Item 1. Enter the name of the plan in which you are presently enrolled.

Item 2. Enter your present enrollment code.