



**SAMPLE OF A COMPLETED OPEN SEASON ELECTION FORM**  
 Pages 1-4 of the form instructions provide more detailed information.

Form Approved:  
 OMB No. 3206-0160

**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) Surname, First M		2. Social Security Number 999-99-9999		3. Date of birth (mm/dd/yyyy) 01/23/1234		4. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		5. Are you married? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
6. Home mailing address (including ZIP Code) 111 Resident Street Name City, ST 99999				7. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		8. Medicare Claim Number Response is required.			
10. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input checked="" type="checkbox"/> Other Name of other insurance: Secondary Health Insurance Policy Number: 123456789 <input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.				9. Are you covered by insurance other than Medicare? <input checked="" type="checkbox"/> Yes, indicate in item 10 below. <input type="checkbox"/> No					
11. Email address My.Email.Address@homeorwork.com				12. Preferred telephone number 123-456-7890					
13. Name of family member (last, first, middle initial) Surname, Spouse M.		14. Social Security Number 888-88-8888		15. Date of birth (mm/dd/yyyy) 11/11/1234		16. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		17. Relationship code 01	
18. Address (if different from enrollee) This box should only be checked if you will be covered under two FEHB plans after this election is processed. It alerts you and HR that action must be taken to avoid dual enrollment.				19. If this family member is covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		20. Medicare Claim Number See item 15 on page 2 of the instructions form for the relationship code.			
22. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other Name of other insurance: Policy Number: <input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.				21. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 22 below. <input checked="" type="checkbox"/> No					
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) Surname, Child M.		26. Social Security Number 777-77-7777		27. Date of birth (mm/dd/yyyy) 11/22/1234		28. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		29. Relationship code 19	
30. Address (if different from enrollee)				31. If this family member is covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		32. Medicare Claim Number			
34. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other Name of other insurance: Policy Number: <input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.				33. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 34 below. <input type="checkbox"/> No					
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) Surname, Step M.		38. Social Security Number 666-66-6666		39. Date of birth (mm/dd/yyyy) 11/11/1345		40. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		41. Relationship code 17	
42. Address (if different from enrollee)				43. If this family member is covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		44. Medicare Claim Number			
46. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other Name of other insurance: Policy Number: <input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.				45. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 46 below. <input type="checkbox"/> No					
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)

For agency distribution of copies, see page 5 of the instructions.

Enrollee name

Look for the enrollment code on the cover page of the plan brochure. The first two digits are for the specific plan you have chosen. The third digit indicates whether it is a self-only, self plus one, or self and family enrollment. The three digit codes for all FEHB plans are also listed on OPM's website.

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

1. Plan name  
Current FEHB Plan Name

2. Enrollment code  
991

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

1. Plan name  
New FEHB Plan Name

2. Enrollment code  
992

**Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2)**

1. Event code  
1B

1B means Open Season Election

2. Date of event  
11/14/2016

**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 (Annuity/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.

This date must be during Open Season 11/14/2016-12/12/2016. Use the date you completed the form.

**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)

Be sure to sign and date. Fax to 612-336-3545 and keep the fax confirmation sheet for your records.

2. Date (mm/dd/yyyy)  
11/16/2016

**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 ( )

You must use the current version of the form, dated November 2015. Outdated versions will not be accepted. Our website will also have the correct version posted. <https://www.opm.gov/forms/>