Form Approved: OMB No. 3206-0160

Federal Employees Health Benefits Program

Health Benefits Election Form

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Part B - FEHB Plan You Are Currently Enrolled In (if applicable)		Part C - FEHB Plan You Are Enrolling In or Changing To		
1. Plan name	2. Enrollment code	1. Plan name	2. Enrollment code	
Part D - Event That Permits You To	Enroll, Change, or Cancel (see page 2)	Part E - Election NOT to Enroll (Emple	ovees Only)	
1. Event code	2. Date of event	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		Part G - Suspension of FEHB (Annuite	unts/Former Spouses Only)	
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.		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.		
Part H - Signature				
<u> </u>		ntation relative thereto is a violation of the law	punishable by a fine of not more than	
1. Your signature (do not print)		2. Date (2. Date (mm/dd/yyyy)	
3. Email address		4. Prefei	4. Preferred telephone number	
Part I -To be completed by agency o	r retirement system			
REMARKS	·			
Date received (mm/dd/yyyy)	2. Effective date of action (<i>n</i>	nm/dd/yyyy) 3. Personnel telephone	number	
4. Name and address of agency or retirement system		5. Authorizing official	5. Authorizing official (please print)	
		6. Signature of authoriz	zed agency official	
7. Payroll office number	8. Payroll office contact (pla	9. Payroll telephone nu	mber	