

REQUEST TO CHANGE FEHB ENROLLMENT FOR 2013 PLAN YEAR

Read the enclosed instructions before completing this form. Return this form to:
USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161
You may fax your form to 888-212-8734.

Do not take any action to maintain your present coverage.

COMPLETE THIS FORM ONLY IF YOU ARE MAKING CHANGES.

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at www.opm.gov/insure/health.

SECTION I - Enrollee and Family Member Information (For additional family members use a separate sheet and attach.)

1. ENROLLEE NAME (last, first, middle initial)		2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH (mm/dd/yyyy)	4. SEX <input type="checkbox"/> M <input type="checkbox"/> F	5. ARE YOU MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO
6. HOME MAILING ADDRESS (including ZIP Code)		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	
		9. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? <input type="checkbox"/> YES, indicate in item 10 below. <input type="checkbox"/> NO			
10. INDICATE THE TYPE(S) OF OTHER INSURANCE <input type="checkbox"/> TRICARE <input type="checkbox"/> OTHER <input type="checkbox"/> FEHB		NAME OF OTHER INSURANCE		POLICY NUMBER	

Dependents' Information. Fill in the applicable information in the blocks below. For additional family members please use a separate sheet of paper. Relationship Codes are: 01. Spouse; 19. Child under age 26; 09. Adopted child; 17. Step child; 10. Eligible foster child; 99. Disabled child age 26 or older who is incapable of self-support because of a physical or mental disability that began before his/her 26th birthday.

11. NAME OF FAMILY MEMBER (last, first, middle initial)		12. SOCIAL SECURITY NUMBER	13. DATE OF BIRTH (mm/dd/yyyy)	14. SEX <input type="checkbox"/> M <input type="checkbox"/> F	15. RELATIONSHIP CODE
16. ADDRESS (if different from enrollee)		17. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		18. MEDICARE CLAIM NUMBER	
		19. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? <input type="checkbox"/> YES, indicate in item 20 below. <input type="checkbox"/> NO			
20. INDICATE THE TYPE(S) OF OTHER INSURANCE <input type="checkbox"/> TRICARE <input type="checkbox"/> OTHER <input type="checkbox"/> FEHB		NAME OF OTHER INSURANCE		POLICY NUMBER	
21. EMAIL ADDRESS (if home address is different from enrollee's)		22. PREFERRED TELEPHONE NUMBER (if home address is different from enrollee's)			

23. NAME OF FAMILY MEMBER (last, first, middle initial)		24. SOCIAL SECURITY NUMBER	25. DATE OF BIRTH (mm/dd/yyyy)	26. SEX <input type="checkbox"/> M <input type="checkbox"/> F	27. RELATIONSHIP CODE
28. ADDRESS (if different from enrollee)		29. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		30. MEDICARE CLAIM NUMBER	
		31. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? <input type="checkbox"/> YES, indicate in item 32 below. <input type="checkbox"/> NO			
32. INDICATE THE TYPE(S) OF OTHER INSURANCE <input type="checkbox"/> TRICARE <input type="checkbox"/> OTHER <input type="checkbox"/> FEHB		NAME OF OTHER INSURANCE		POLICY NUMBER	
33. EMAIL ADDRESS (if home address is different from enrollee's)		34. PREFERRED TELEPHONE NUMBER (if home address is different from enrollee's)			

SECTION II - FEHB Plan You Are Currently Enrolled In		Section III - FEHB Plan You Are Changing to	
1. PLAN NAME	2. ENROLLMENT CODE	1. PLAN NAME	2. ENROLLMENT CODE

SECTION IV - 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)	2. DATE (mm/dd/yyyy)
3. EMAIL ADDRESS	4. PREFERRED TELEPHONE NUMBER ()