



# Direct Premium Remittance System (DPRS)



## PUBLICATION CATEGORY

Enter publication category Insurance Processing

## PROCEDURE MANUAL

Direct Premium Remittance System (DPRS)





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## Latest Update Information

The following changes have been made to the Direct Premium Remittance System (DPRS) procedure:

Section	Description of Change
<i>Log in to DPRW</i>	Updated the personnel list and contact information on the home page.
<i>SF 2809, Health Benefits Election Form</i>	Standard Form (SF) 2809 has been changed by Office of Personnel Management (OPM) replacing the Medicare Claim Number fields with the new Medicare Beneficiary Identifier.
<i>SF 2809, Types of New Enrollments</i> <b>SF 2809 and SF 2810 for Corrections</b>	Replaced SF 2809 and SF 2810 forms with the Medicare Beneficiary Identifier fields.
<i>Appendix II, Instructions on Completing the SF 2809</i>	Replaced the Medicare Claims Number with the new Medicare Beneficiary Identifier.





## Introduction

This procedure provides instructions for Federal Agencies to enroll eligible non-Federally employed individuals in the Direct Premium Remittance System (DPRS). DPRS centralized system for collecting premiums from eligible non-Federal enrollees who elect to participate in the Federal Employees Health Benefits (FEHB) Program under Public Law (P.L.) described below. For more information, see Appendix I, Public Laws Guidelines.

- P.L. 98-615 (5 USC 8905a), Civil Service Retirement Spouse Equity Act of 1984, provides for the enrollment of eligible former spouses of current, retired, or separated Federal employees in the FEHB program.
- Title II of P.L. 100-654 (5 USC 8905a), Federal Employees Health Benefits Amendments Act of 1988, provides for temporary continuation of coverage (TCC) under FEHB for (1) certain individuals who separate from Federal service, (2) children (of Federal employees, annuitants, or separated employees already enrolled in FEHB) who lost their status as family members, and (3) certain former spouses of current or separated Federal employees or annuitants who would otherwise not be eligible for continued FEHB coverage.
- P.L. 101-303 (5 USC 8906I), Direct Pay Annuitant/Survivors, provides for annuitants/survivors to pay health benefits premiums directly to the National Finance Center (NFC) when the annuity is insufficient to pay the withholdings for the plan that the annuitant/survivor is enrolled in.
- P.L. 102-484, National Defense Authorization Act for Fiscal Year 1993, amends the TCC under FEHB for certain civilian employees of the Department of Defense (DOD) separated under the reduction in force.
- P.L. 104-106, National Defense Authorization Act for Fiscal Year 1996, amends the TCC under FEHB to cover employees who voluntarily separate from surplus positions.

Each of these laws establishes a requirement that Agencies provide FEHB coverage for qualified enrollees. The Office of Personnel Management (OPM) has contracted with the United States Department of Agriculture's (USDA) NFC to act as the central processing office for P.L. 98-615 and P.L. 100-654 accounts. Those Agencies that elect to use NFC's services will have their accounts processed through DPRS.

Individuals who are eligible for extended FEHB coverage under P.L. 98-615, P.L. 100-654, P.L. 102-484, or P.L. 101-303 apply for initial enrollment by providing their Agency submitting offices with a completed SF 2809, see SF 2809, Health Benefits Election Form and Appendix II, Instructions on Completing the SF 2809. For examples of completed SF 2809s, see SF 2809, Types of New Enrollments.

Only annuitants and survivors on direct-pay are serviced by NFC.



This section includes the following topics:

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<b>Accessibility</b> .....	<b>4</b>
<b>New Enrollment Requirements</b> .....	<b>4</b>
<b>Overall Functional Description of Direct Premium Remittance Web (DPRW)</b> .....	<b>6</b>
<b>Resources</b> .....	<b>6</b>

## Background

DPRS is a centralized system for billing and collecting premiums from eligible non-Federal enrollees who elect to participate in FEHB and Federal annuitants/survivors who are placed in direct-pay due to insufficient net annuity pay.

## Accessibility

The DPRS screens provide additional information in your Web browser about the content they display. Fields on the screen include information about their titles or purpose. *Links* and **buttons** include descriptive information about their function. If and how this information is displayed and used depends on the Web browser and/or accessibility software you are using, and functionality varies among different web browsers. Consult the documentation provided with your Web browser and/or accessibility software for more information.

Screen reader users should "arrow" through screens to ensure that all form instructions are announced.

### Usage Preferences

The style and format of the DPRS screens provide a clean and organized display of form instructions and fields. Using your Web browser's menu, change the font to the size you prefer. Refer to your Web browser's documentation for details. You may also disable the DPRS style sheet and use the default style provided by your Web browser by adjusting your Web browser's settings.

## New Enrollment Requirements

### To Establish a New Enrollment

<b>Agencies</b>	Advise eligible individuals of coverage available under P.L. 98-615 and P.L. 100-654.
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<b>Eligible Enrollees</b>	Prepare an SF 2809 and forward to Agency.
<b>Agencies</b>	Complete an SF 2809 and establish enrollee into DPRW for a DPRS enrollment.
<b>NFC</b>	Generate an SF 2809 copy to FEHB carrier. Forward enrollee coupon book for making payments through lock box. Monitor enrollee accounts. Provide reporting to OPM and carrier.

Before entering into DPRW, the Agency must enter the following information on the SF 2809:

- Effective date of the enrollment
- Enrollment code
- Submitting Office Number (SON) (the document will fail processing if the SON is missing or incorrect and enrollment of the applicant may be delayed.)
- The following information must be included in the Remarks block in exactly the order shown, as appropriate for the class of the enrollee:

**Separated employee:**

- Relationship (self)
- P.L. under which the applicant is eligible using the law's whole number (i.e., P.L. 100-654 (5 U.S.C. 8905a))
- Date of separation
- Last day of pay period

**Former spouse and child of a current employee:**

- Relationship (ex-spouse, child)
- P.L. under which the applicant is eligible for benefits, using the law's whole number (e.g., P.L. 98-615 or P.L. 100-654 (5 U.S.C. 8905a))
- Name of the employee
- SSN of the employee
- Date of birth (DOB) for the employee
- Date of the qualifying event (e.g., divorce, annulment, date of 26th birthday, P.L. 100-654 enrollees only)

**Former spouse and child of a separated employee:**

- Persons in this category should contact NFC directly for enrollment information.



**Former spouse and child of CSRS, FERS, or other retirement systems' annuitants:**

- OPM will continue to process all accounts for their annuitants' children or former spouses. Forms for these individuals should be sent to OPM, not to NFC.
- The original employee/former employee information will be needed to establish a DPRS enrollee master, to determine the enrollment expiration date in the case of P.L 100-654 enrollees, and to provide this information to the carrier.
- After all information is complete, the submitting office should return the enrollee's copy to the enrollee and keep the new carrier copy for the records.

Upon receipt of the initial SF 2809 for enrollment into a plan, NFC will generate a copy of the SF 2809 to the carrier and establish an enrollee master in the DPRS database.

## **Overall Functional Description of Direct Premium Remittance Web (DPRW)**

Previously, DPRS functionality was a manual process. DPRW is an Oracle Web-based front end to accommodate the functions performed by Payroll Offices, Human Resources (HR), individual enrollee's NFC Administrators, and OPM personnel.

The purpose is to design, develop, and implement an Oracle Web-based front end for DPRW to mimic the functionality for both Standard Form (SF) 2809, Health Benefits Election, see SF 2809, Health Benefits Election Form and SF 2810, Notice of Change in Health Benefits, see SF 2810, Notice of Change in Health Benefits Enrollment. All data that Agencies are currently completing on the hard copy SF 2809 form will be entered into the DPRW portal pages. Agency officials will be required to certify the document through the portal, thus confirming eligibility for the FEHB enrollment.

### **The Benefits of DPRW:**

DPRW increases efficiency of the TCC enrollment process by eliminating mailing and faxing of hard copy enrollments. Having HR Offices enter their own documents significantly decreases the time it takes an enrollee to get enrolled by the carrier and receive ID cards and billing coupons. Original hard copies no longer need to be sent to NFC. This is also a savings in postage costs.

## **Resources**

A DPRW participant guide is available from the DPRS Web site at [https://www.nfc.usda.gov/Training/Resources/DPRW\\_Participant\\_Guide.pdf](https://www.nfc.usda.gov/Training/Resources/DPRW_Participant_Guide.pdf). Users are encouraged to read the guide in advance of receiving their user ID and password from NFC Security.









## Responsibilities

This section explains the responsibilities of the primary organizations involved in data processing and system maintenance.

This section includes the following topics:

<b>Agency Responsibilities .....</b>	<b>9</b>
<b>Office of Personnel Management (OPM) Responsibilities .....</b>	<b>10</b>
<b>National Finance Center (NFC) Responsibilities.....</b>	<b>10</b>

## Agency Responsibilities

Below are the responsibilities of the primary organizations.

### Agency submitting offices will:

- Inform separating employees of their eligibility and that of their children and former spouses under the expanded FEHB coverage.
- Inform separating employees of the eligibility time restraints imposed under the expanded FEHB coverage. (See Federal Personnel Manual (FPM) bulletins 890-179 and 890-186 for information on eligibility.)
- Determine the eligibility of separated employees, children, and former spouses of current employees for the expanded FEHB coverage. (See FPM bulletins 890-179 and 890-186 for information on eligibility.)
- Determine the eligibility of separated employees, children, and former spouses to enroll under the requested plan. (Those who signed up for a Health Maintenance Organization (HMO) are not eligible.)
- Receive the initialed SF 2809 from the enrollee and ensure that the information is accurate, complete, and signed by both the enrollee and an Agency official.
- Complete the Agency or Retirement System portion of the SF 2809 (Part I), by identifying the Public Law covering the enrollee (either P.L. 98-615 - Civil Service Retirement Spouse Equity Act of 1984 (Law 1) or P.L. 100-654 - Temporary Continuation - 5 USC 8905a or P.L. 102-484 National Defense Authorization Act for Fiscal Year 1993) along with their submitting office number, date of qualifying event, and additional information regarding the original employee.
- Return the enrollee's copy of the SF 2809 and/or SF 2810 to the enrollee, keep the new carrier copy for its records, and establish enrollee in DPRW. Prepare the SF 2810 and attach the initialed SF 2809 with the additional enrollment information required for the transfer of Spouse Equity Act enrollees to NFC.



- Enter all new enrollments, SF 2809 and/or SF 2810 in DPRW.
- Respond to inquiries from NFC personnel relating to the initial SF 2809 and data submitted for new enrollees.
- Verify printed SF 2809 (if prior to June 1988), then include enrollee and Agency telephone numbers and effective date of Other Insurance.
- Review the monthly report DPRS 1501 to ensure that all SF 2809s submitted by their office have been processed correctly.
- Forward semi-monthly report DPRS 1601 to the retirement section of the Agency payroll office.
- Before the registration has been certified in DPRW, enter any corrections to the initial SF 2809 or SF 2810 as a result of an administrative error.
- Explain to the enrollee that they must pay the total cost of the coverage (their share and the amount the Government normally contributes for the employee, P.L. 100-654).
- Advise the enrollee to plan for any normal medical needs (especially with HMOs). There could be a delay of 30-45 days before an enrollee is established on the carrier's system. NFC sends information to the carriers every Wednesday. It takes the carriers at least 2 weeks after receipt to establish the enrollee into the applicable plan. Also, NFC will bill the enrollee on the first of the month following the latter of the effective date of coverage or the date established in our system.

## Office of Personnel Management (OPM) Responsibilities

Below are the responsibilities of OPM.

### OPM will:

- Determine eligibility of retirees and survivors eligible under P.L. 101-303, Direct Pay Annuitant/Survivors.
- Complete the Agency or Retirement System portion of the SF 2809/SF 2810 identifying the public law covering the enrollee.
- Return the enrollees copy of the SF 2809/SF 2810 to the enrollee and establish the enrollment or transfer-in in the DPRW enrollment portal.

## National Finance Center (NFC) Responsibilities

Below are the responsibilities of NFC.

### NFC will:

- Maintain enrollee accounts.



- Respond to billing and collections inquiries.
- Process subsequent changes in enrollment for all categories of enrollees.
- Handle open season processing.
- Coordinate the transfer of TCC and Spouse Equity enrollees.
- Determine the eligibility for reinstatement of an enrollee maintained by DPRS.
- Provide enrollees with correspondence relating to their enrollment in DPRS after their initial enrollment.





## System Access to DPRW

This section provides access security information and gives specific login/log-out instructions.

This section includes the following topics:

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<b>Log in to DPRW</b> .....	<b>13</b>
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### Security Access

To access DPRW, you must (1) have authorized security clearance and (2) use a computer that is connected to the Internet. Agencies must request access to this application through their Agencies NFC security officers.

Authorized Roles are as follows:

- HR
- OPM
- NFC Operations
- Auditor - read only

### Log in to DPRW

The personnel list and contact information on the FEHB DPRS program page have been updated.

To establish enrollments into DPRW, the following steps are required:

**To Log in to DPRW:**

1. Connect to the *NFC Home page* (<http://www.nfc.usda.gov>).
2. Go to the MyNFC drop-down menu. Select Insurance Services Clients.



3. Select the DPRW icon on the Launch an Application menu. The DPRW Warning page is displayed.

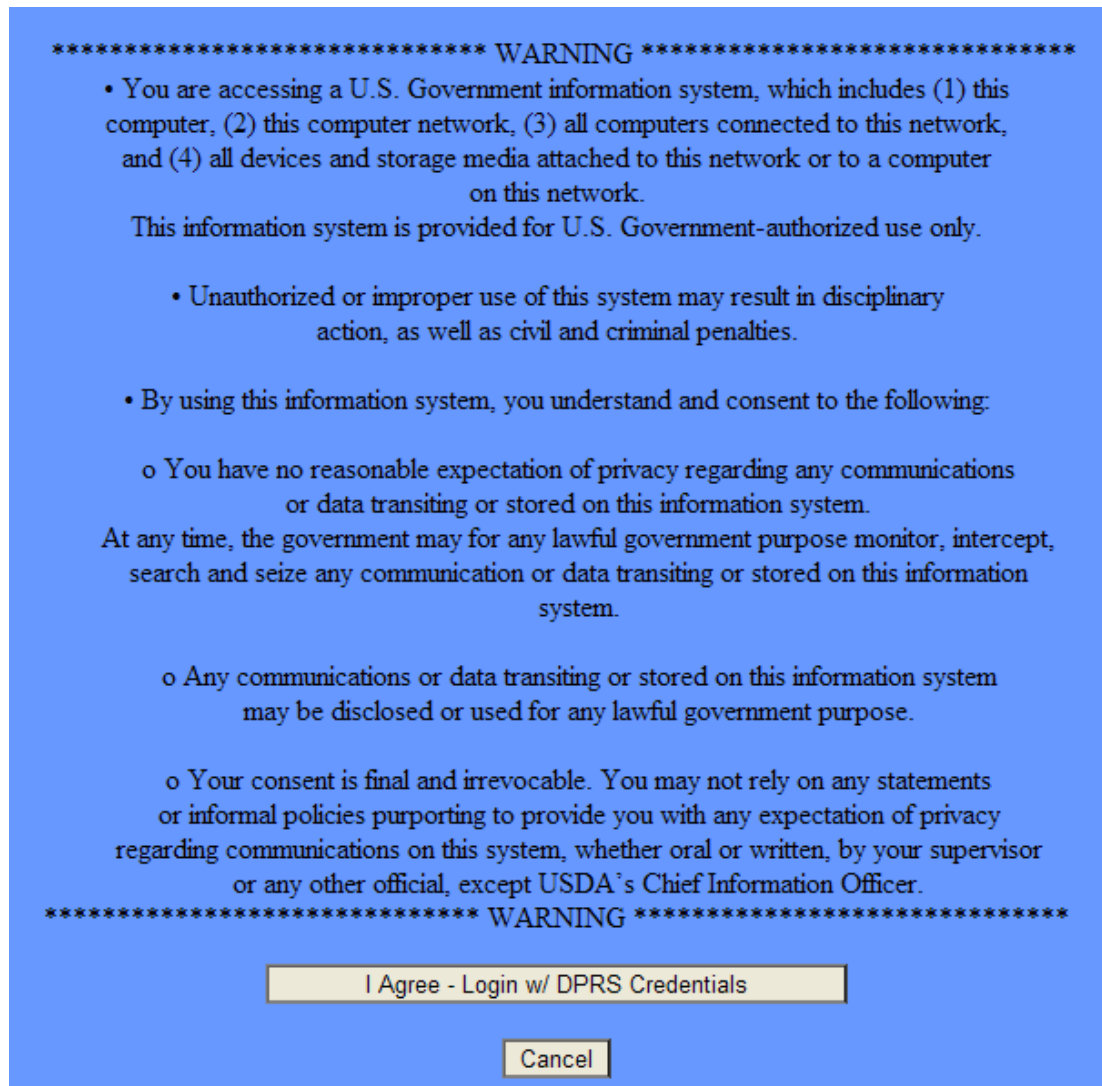


Figure 1: DPRS Warning Page

4. Read the warning and select the **I Agree - Login w/DPRS Credentials** button. The DPRS Login page is displayed.



**OR**

Select the **Cancel** button to return to the Internet.

**Direct Premium Remittance System (DPRS)**

User ID

Password

Change Password

Login

**Figure 2: Direct Premium Remittance System (DPRS) Login Page**

5. Complete the fields as follows:

*User ID* (see "*User ID Field Instruction*" on page 101)

*Password* (see "*Password Field Instruction*" on page 97)



6. Select the **Login** button. The FEHB DPRS program page is displayed.

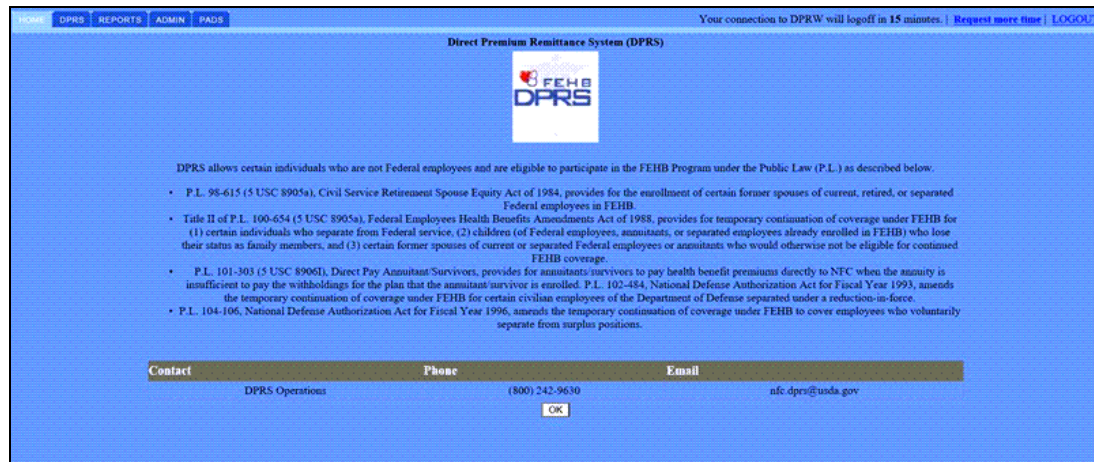


Figure 3: Direct Premium Remittance System (DPRS) FEHB Program Page

7. Select the **DPRS** tab.

**OR**

Select the **OK** button. This will automatically bring you to the DPRS menu page.

DPRW consists of three tabs: **HOME**, **DPRS**, and **REPORTS**.

- The **HOME** tab contains applicable laws, guidance, and contact information.
- The **DPRS** tab is used to add new enrollments, search and complete existing enrollments, and correct enrollments that have not been processed in the nightly batch job or to view certified records that have been processed to the DPRS mainframe.
- The **REPORTS** tab displays links to DPRS reports.





## Change Password

### To Change Your Password:

1. At the Login to DPRS page, enter your User ID and Password.

**Direct Premium Remittance System (DPRS)**

User ID

Password

Change Password

Login

Figure 4: Direct Premium Remittance System (DPRS) Login Page

2. Select the **Change Password** box. You may change your password at any time.
3. Select the **Login** button. The fields necessary to change your password are displayed.

Enter new password

Confirm new password

Save Cancel

**Your password has expired**  
**You must change your password**

Figure 5: Change Password Page

4. Complete the fields as follows to change a password:



*Enter new password* (see "*Enter New Password Field Instruction*" on page 93)

*Confirm new password* (see "*Confirm New Password Field Instruction*" on page 90)

5. Select the **Save** button.

Once **Save** is selected, the Password Changed popup appears as confirmation that your password successfully updated.

**OR**

If the passwords do not match, an error message will appear *Password and Confirmation do not match*.

## Exiting DPRW

To exit DPRW, select **LOGOUT** on any DPRW page. The DPRS log-out page is displayed with the message *You have successfully logged out of Direct Premium Remittance System. For security reasons this browser window will automatically close, and the current session is terminated.* For the highest security when logging off, close the browser to keep another user from accessing pages in the browser memory.

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Note: Any unsaved changes will be lost.

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## DPRS Menu

The DPRS Menu generates new enrollees, searches/completes a new enrollee's registration, and makes corrections to a new enrollee's registration before the enrollment is processed or generated.

HOME DPRS REPORTS [LOGOUT](#)

### DPRS Menu

**Enter a Social Security Number and choose a button.**

Social Security Number

---

**Enter a Name and choose Search Name button.**

First Name

Middle Initial

Last Name \*

Figure 6: DPRS Menu Page

### To Establish New Enrollments in DPRS:

1. Enter the Social Security Number.
2. Select one of the following buttons:

**Add Registration SF2809** (see "Add Registration SF2809 Field Instruction" on page 89)

**Search/Complete Registration SF2809** (see "Search/Complete Registration SF2809 Field Instruction" on page 99)

**Correct Registration SF2809** (see "Correct Registration SF2809 Field Instruction" on page 90)

**View Certified SF2809** (see "View Certified SF2809 Field Instruction" on page 101)



**OR**

If the enrollee has been certified and is in the DPRS mainframe, enter the enrollee's last name.

The screenshot shows the DPRS Menu page with a blue header and navigation tabs for HOME, DPRS, and REPORTS. A LOGOUT link is in the top right. The main content area is titled "DPRS Menu" and contains two sections. The first section, "Enter a Social Security Number and choose a button.", has a text input for "Social Security Number" and three buttons: "Add Registration SF2809", "Search/Complete Registration SF2809", and "Correct Registration SF2809". Below it is a "View Certified SF2809" button. The second section, "Enter a Name and choose Search Name button.", has text inputs for "First Name", "Middle Initial", and "Last Name \*" (with "MARKS" entered). A "Search Name" button is below. At the bottom is a table with columns: Action, First Name, Middle Initial, Last Name, SSN, Birthday, Address, Address2, City, State, Zip. The table contains one row with the following data: Action (Search/Complete, Correct, View), First Name (TRAINER), Middle Initial, Last Name (MARKS), SSN (XXXXXXXXXXXXXXXXXXXX), Birthday (XXXXXXXXXX12:00:00 AM), Address (XXX LUNDENWOOD LN), Address2, City (NORTHBROOK), State (IL), Zip.

**Figure 7: DPRS Menu Page (Search Name)**

3. Select the **Search Name** button. A name or list of names is returned from the DPRS mainframe for the user to select. Each unique record (First Name, Middle Initial, Last Name, SSN, Birthday, Address, City, State, and ZIP Code) for the enrollee will be displayed.
4. Select the **Search/Complete** button to update/complete the enrollee's information. If the enrollee has been certified, a message will appear, *SSN Certified on Mainframe. Contact DPRS Operation, at 800-242-9630 or Email DPRS Operation <https://www.nfc.usda.gov/ClientServices/Insurance/services/dprs/contact.php> for changes.*

**OR**

Select the **Correct** button to updated any information on the enrollee's initial enrollment. If the enrollee has been certified, a message will appear, *SSN Certified on Mainframe. Contact DPRS Operation, at 800-242-9630 or Email DPRS Operation <https://www.nfc.usda.gov/ClientServices/Insurance/services/dprs/contact.php> for changes.*

**OR**

Select the **View** button to review the initial enrollment information. If the enrollee has been certified, a message will appear, *SSN Certified on Mainframe. Contact DPRS Operation, at 800-242-9630 or Email DPRS Operation <https://www.nfc.usda.gov/ClientServices/Insurance/services/dprs/contact.php> for changes.*



## Operating Features

DPRS is designed in a Web format providing mouse-driven point-and-click functionality, command buttons, and other Web features. This section reviews these basic features and describes other features that are specific to DPRS.

This section includes the following topics:

<b>Command Buttons</b> .....	<b>21</b>
<b>Popups</b> .....	<b>22</b>
<b>Drop-Down Menus</b> .....	<b>22</b>

## Command Buttons

DPRS command buttons carry out the action described in the button's name. The following command buttons are used throughout DPRS:

- **Add Family** - Opens a page to establish additional enrollments on current employee.
- **Add Registration SF2809** - Opens a page to establish enrollment of a family member for current employee.
- **Back** - Moves back to the previous page on existing enrollee.
- **Cancel** - Removes the data entry from the page and returns to the previous page.
- **Correct Registration SF2809** - Provides Agencies the capability to modify the data for SF 2809. Only a certified official can modify the registration.
- **Delete** - Deletes an existing enrollment.
- **Reset Family** - Deletes the data and refreshes a page.
- **Save or Save SF2809** - Saves the data entered on each individual SF 2809 page.
- **Search/Complete Registration SF2809** - Opens the enrollee information page.
- **Search Name** - Searches the data by the name of the existing enrollee.
- **Update Family** - Displays a list of family members on the existing enrollee with options to edit or delete.
- **View Certified SF2809** - Displays the data on each page of the certified SF 2809 available.



## Popups

Throughout DPRS, a popup will appear when certain actions are performed. The popup will notify the user of an action that must be taken and/or an error condition that must be corrected. Command buttons are used on the popup to accept or cancel the message. You must select a command button for the popup to disappear and to be returned to the active page.

## Drop-Down Menus

Many DPRS pages have drop-down menu data entry fields that allow you to select the correct entry value from a list of valid values for that field.

### **To Complete a Drop-Down Menu Data Entry Field:**

1. Select the arrow displayed next to the drop-down menu data entry field and the drop-down menu of valid values for that field is displayed.
2. Select the arrows that are displayed at the top and bottom of the drop-down menu to scroll through the menu and locate the appropriate value.
3. Select the appropriate value and that value is entered into the field.

---

Note: The values displayed in the drop-down menus are listed in numeric/alphabetical order. You may enter the first character of a value in the field displayed next to the arrow in order to display the first value that begins with that character.

---



## Inquiries

This section explains the responsibilities of the primary organizations on all questions regarding eligibility and accounts.

This section includes the following topics:

<b>Agency Inquiries</b> .....	<b>23</b>
<b>National Finance Center (NFC) Inquiries</b> .....	<b>23</b>
<b>OPM Inquiries</b> .....	<b>23</b>

### Agency Inquiries

#### Agency submitting offices:

Questions relating to the eligibility of separated employees and former spouses/children of current employees will be handled by the submitting office.

### National Finance Center (NFC) Inquiries

#### NFC:

All questions from enrollees and/or their Agencies regarding their accounts should be referred to and will be handled by NFC.

NFC may refer a question/problem to the HR Office of the employing Agency for final ruling or clarification through the appropriate channel to OPM.

NFC has established a toll free telephone inquiry line for DPRS enrollees. The number is **1-800-242-9630**. The line is available from 8:00 a.m. to 4:00 p.m., central time, Monday through Friday (except Federal holidays).

### OPM Inquiries

#### OPM:

All questions related to retirement processing or changes prior to the transfer-in date of an annuitant/survivor will be handled by OPM's Insurance and Retirement Group.







## Establish Enrollment

Individuals who are eligible for extended FEHB coverage under the P.L. 98-615, P.L. 100-654, P.L. 102-484, or P.L. 101-303 will apply for initial enrollment by providing their Agency submitting offices with a completed SF 2809, Health Benefits Registration form. The Federal Agencies will enroll the eligible non-Federally employed individuals in DPRS.

This section includes the following topics:

<b>Forms That are Required for DPRS</b> .....	<b>25</b>
<b>Who May Use an SF 2809</b> .....	<b>26</b>
<b>DPRS Transaction Batch Codes</b> .....	<b>27</b>

## Forms That are Required for DPRS

Forms associated with DPRS activities are described below.

### **SF 2809, Employee Health Benefits Election Form**

This form is used by (1) Federal employees eligible to enroll in or currently enrolled in the FEHB program, (2) former spouses of Federal employees eligible to enroll in or currently enrolled in the FEHB program under the Spouse Equity law, and (3) individuals eligible for temporary continuation of coverage under the FEHB program to:

- Enroll or re-enroll in the FEHB Program.
- Elect not to enroll in the FEHB Program (*employee only*).
- Change enrollee's plan.
- Change coverage within a plan.
- Cancel FEHB enrollment of an enrollee who elected to end coverage though continues to be eligible for it, and no extension of coverage is grant.
- Suspend FEHB enrollment (*annuitants or former spouses only*).

### **SF 2810, Notice of Change in Health Benefits Enrollment**

This form is used to:

- Terminate:
  - Enrollee employed by the Federal Government who leaves Government service



- Enrollee employed by the Federal Government who exceeds 365 days in non-pay status and is eligible for a 31-day extension of coverage
- Conversion to Nongroup Contract
- Time Limited on Conversion
- Temporary Continuation of Coverage
- Entry on Active Military Duty
- Transfer:
  - Employment
  - Retirement
  - Death
  - Employees' compensation
- Reinstate enrollment.
- Change the name of an enrollee.
- Change the enrollment to a survivor annuitant.

---

Note: The SF 2809 and SF 2810 options in DPRS are formatted to include data elements from the forms listed above, as well as the data elements from the SF 2809 and SF 2810 options in Employee Express.

---

## Who May Use an SF 2809

1. Employees eligible to enroll in or currently enrolled in the FEHB Program, including temporary employees eligible under 5 United States Code (U.S.C.) 8906a. Employees automatically participate in premium conversion unless they waive it.
2. Annuitants in retirement systems other than the Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS), including individuals receiving monthly compensation from the Office of Workers' Compensation Programs (OWCP).

---

Note: CSRS and FERS annuitants and former spouses and children of CSRS/FERS annuitants - **do not use this form**. Instead, use OPM 2809, Health Benefits Registration Form (only for use by Annuitants and Former Spouses of Annuitants), which is available at [www.opm.gov/retire](http://www.opm.gov/retire), or call the Retirement Information Office toll free at **1-888-767-6738**.

---

3. Former spouses eligible to enroll in or currently enrolled in the FEHB Program under the Spouse Equity law or similar statutes.
4. Individuals eligible for TCC under the FEHB Program, including:



- Former employees (who separated from service)
- Children who lose FEHB coverage
- Former spouses who are not eligible for FEHB under the Spouse Equity law or similar statutes

## DPRS Transaction Batch Codes

The following are batch codes used in DPRS:

- **AW01** - New Enrollment
- **BW01** - Transfer-In Enrollment
- **CW04** - Change/correct original enrollee and/or dependent (sex, SSN, marital status, other insurance, and family)
- **DW03** - Change/correct original enrollee and/or dependent (name, date of birth, address, Department of Defense (DOD) component, activity, location, domestic address indicator, phone number, State, ZIP Code, country code, and SON)





## New Enrollments in DPRW

DPRW enables HR Agencies and OPM to enter the new enrollments into DPRS through the Web interface. Once the online SF 2809s and SF 2810s are certified to be sent to NFC, they are picked up and processed in a nightly batch processing. The data is validated and submitted to the DPRS Mainframe system. After the nightly processing, either a new enrollment record or a suspense record is created in DPRS. NFC Operations reviews and clears all suspense in DPRS.

This section includes the following topics:

<b>Enrollment Records</b> .....	<b>29</b>
<b>New Enrollee SF2809 Part A Family Information</b> .....	<b>29</b>
<b>Public Law, Spouse Equity</b> .....	<b>33</b>
<b>New Enrollee SF 2809 Part A</b> .....	<b>34</b>
<b>New Enrollee SF 2809 Part B</b> .....	<b>37</b>

## Enrollment Records

There are four parts to an enrollment record in DPRW.

Enrollment Records	Description
<b>Part A</b>	This page contains the overall enrollee information. The required fields on this page must be completed before the record can be saved.
<b>Family Information</b>	As a supplemental page to Part A, this page contains the dependent information.
<b>Part B</b>	This page displays different fields based on the Public Law selected on Part A. It contains information on the event that enables the enrollment.
<b>Part C</b>	This page contains the information on the processing of the action including the processing office and effective date of the enrollment.

## New Enrollee SF2809 Part A Family Information

The SF 2809 Part A is used to establish enrollment for a family policy.



## To Establish Enrollment for a Family Policy:

1. On the SF 2809 Part A page, select the **Family Info** option to enter the dependent information. The SF2809 Part A Family Information page is displayed.

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SF2809 Part A

[Enrollee Info](#) [Part B](#) [Part C](#) Save SF2809 Back

**Family Information**

First Name Middle Initial Last Name Social Security Number  
Jessica [ ] Smith XXXXXXXXX

Date of Birth Sex Relationship  
09-02-1990 [ ] Female 19 - CHILD UNDER AGE 26

Country Domestic  
UNITED STATES Yes

Address 1 Address 2 City State Zip  
308 Dog Rd [ ] City State XXXXX

Home Phone Work Phone Cell Phone Email  
[ ] [ ] XXXXXXXXXXXX [ ]

Other Insurance Medicare Claim Number Other Insurance Name Insurance Policy Number  
None [ ] [ ] [ ]

Add Family Update Family Reset Family

Figure 8: SF2809 Part A, Family Information Page

2. Complete SF2809 Part A, Enrollee Info fields as follows:

**First Name** (see "**First Name Field Instruction**" on page 94)

**Middle Initial** (see "**Middle Initial Field Instruction**" on page 96)

**Last Name** (see "**Last Name Field Instruction**" on page 95)

**Social Security Number** (see "**Social Security Number Field Instruction**" on page 100)

**Date of Birth** (see "**Date of Birth Field Instruction**" on page 91)

**Sex** (see "**Sex Field Instruction**" on page 100)

**Relationship** (see "**Relationship Field Instruction**" on page 98)

**Country** (see "**Country Field Instruction**" on page 91)

**Domestic** (see "**Domestic Field Instruction**" on page 92)

**Address 1** (see "**Address 1 Field Instruction**" on page 89)



*Address 2* (see "*Address 2 Field Instruction*" on page 90)

*City* (see "*City Field Instruction*" on page 90)

*State* (see "*State Field Instruction*" on page 101)

*Zip* (see "*Zip Field Instruction*" on page 101)

*Home Phone* (see "*Home Phone Field Instruction*" on page 94)

*Work Phone* (see "*Work Phone Field Instruction*" on page 101)

*Cell Phone* (see "*Cell Phone Field Instruction*" on page 90)

*Email* (see "*Email Field Instruction*" on page 93)

*Other Insurance* (see "*Other Insurance Field Instruction*" on page 96)

*Medicare Claim Number* (see "*Medicare Claim Number Field Instruction*" on page 95)

*Other Insurance Name* (see "*Other Insurance Name Field Instruction*" on page 97)

*Insurance Policy Number* (see "*Insurance Policy Number Field Instruction*" on page 94)

3. Select the **Add Family** button.
4. Once the required fields are completed, select the **Save SF2809** button.

---

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

---

### **To Edit Enrollment for Family Policy**

1. To make a change to a family member, select the family member.
2. Select the **Edit** button.
3. Update the required fields.



4. Select the **Update Family** button.

**Equation 1: SF2809 Part A, Family Information Page**

HOME DPRS REPORTS

SF2809 Part A

[Enrollee Info](#) [Part B](#) [Part C](#)

**Family Information**

First Name Middle Initial Last Name Social Security Number

Date of Birth Sex Relationship

Country Domestic

UNITED STATES Yes

Address 1 Address 2 City State Zip

Home Phone Work Phone Cell Phone Email

Other Insurance Medicare Claim Number Other Insurance Name Insurance Policy Number

None

Action	Enrollee SEQ	Family Member SEQ	First Name	Middle Initial	Last Name	SSN	Birthday	Sex	Relationship	Address	Address2	City	State	Zip	Zip4	Domestic Indicator
<input type="button" value="Edit"/> <input type="button" value="Delete"/>	2654	1844	trainer	c	smith	XXXXXXXXXX	09-02-1990	F	01	308 dog rd		city	state	XXXXXX		Y
<input type="button" value="Edit"/> <input type="button" value="Delete"/>	2654	1845	trainor	c	smith	XXXXXXXXXX	11-12-1988	M	19	308 dog rd		city	state	XXXXXX		Y

5. Once the dependent is updated, the dependent's information will display at the bottom of the page.

Note: To edit or delete the dependent's information, select the **Edit** or **Delete** button.

**Edit** (see "Edit Field Instruction" on page 93)

**Delete** (see "Delete Field Instruction" on page 92)

6. If no additional information is needed, select the **Save SF2809** button to continue to Part B.

Note: To add more family members, select **Add Family** button. To clear the family information fields for unsaved changes, select the **Reset Family** button.





## Public Law, Spouse Equity

The SF 2809 Part B is used to complete the enrollment for registration based on Public Law, Spouse Equity.

### To Complete Enrollment Based on Public Law, Spouse Equity:

1. On any of the SF 2809 pages, select the **Part B** link to complete the enrollment for registration. The SF2809 Part B page is displayed based on **Public Law, Spouse Equity**.

Figure 9: SF2809 Part B Page, Spouse Equity Public Law

2. Complete the SF2809 Part B - Spouse Equity fields as follows:

---

Note: Required fields are marked with an asterisk.

---

**Event Code** (see "**Event Code Field Description**" on page 93)

**Signature Date** (see "**Signature Date Field Instruction**" on page 100)

**SSN** (see "**SSN Field Instruction**" on page 100)

**DOB** (see "**DOB Field Instruction**" on page 92)

**First Name** (see "**First Name Field Instruction**" on page 94)

**Middle Initial** (see "**Middle Initial Field Instruction**" on page 96)

**Last Name** (see "**Last Name Field Instruction**" on page 95)



**REMARKS** (see "**REMARKS Field Instruction**" on page 99)

3. After completing the fields, select the **Save** button.

**OR**

Select one of the four parts of the enrollment pages, and the record will automatically be saved.

---

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

---

## New Enrollee SF 2809 Part A

The SF 2809 Part A is used to establish enrollment of a child of a current employee, enrollment of a separated employee, or initial enrollment of former spouse of current employee.

### To Establish a New Enrollment:

1. On the DPRS main menu, enter the enrollee's SSN.

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**DPRS Menu**

**Enter a Social Security Number and choose a button.**

Social Security Number

---

**Enter a Name and choose Search Name button.**

First Name

Middle Initial

Last Name \*

Figure 10: DPRS Menu Page



2. Select the **Add Registration SF2809** button. The SF2809 Part A page is displayed.

Figure 11: SF2809 Part A Page

3. Complete Part A - Enrollee Information fields as follows:

---

Note: Required fields are marked with an asterisk.

---

**Public Law** (see "**Public Law Field Instruction**" on page 98)

**Relationship To Employee** (see "**Relationship To Employee Field Instruction**" on page 99)

**Current Enrollment Plan** (see "**Current Enrollment Plan Field Instruction**" on page 91)

**New Enrollment Plan** (see "**New Enrollment Plan Field Instruction**" on page 96)

**First Name** (see "**First Name Field Instruction**" on page 94)

**Middle Initial** (see "**Middle Initial Field Instruction**" on page 96)

**Last Name** (see "**Last Name Field Instruction**" on page 95)

**Social Security Number** (see "**Social Security Number Field Instruction**" on page 100)

**Date of Birth** (see "**Date of Birth Field Instruction**" on page 91)

**Sex** (see "**Sex Field Instruction**" on page 100)



*Married* (see "*Married Field Instruction*" on page 95)

*Country* (see "*Country Field Instruction*" on page 91)

*Domestic* (see "*Domestic Field Instruction*" on page 92)

*Address 1* (see "*Address 1 Field Instruction*" on page 89)

*Address 2* (see "*Address 2 Field Instruction*" on page 90)

*City* (see "*City Field Instruction*" on page 90)

*State* (see "*State Field Instruction*" on page 101)

*Zip* (see "*Zip Field Instruction*" on page 101)

*Home Phone* (see "*Home Phone Field Instruction*" on page 94)

*Work Phone* (see "*Work Phone Field Instruction*" on page 101)

*Cell Phone* (see "*Cell Phone Field Instruction*" on page 90)

*Email* (see "*Email Field Instruction*" on page 93)

*Other Insurance* (see "*Other Insurance Field Instruction*" on page 96)

*Medicare Claim Number* (see "*Medicare Claim Number Field Instruction*" on page 95)

*Other Insurance Name* (see "*Other Insurance Name Field Instruction*" on page 97)

*Insurance Policy Number* (see "*Insurance Policy Number Field Instruction*" on page 94)

*SON Number* (see "*SON Number Field Instruction*" on page 100)

4. After completing the fields, select the **Save SF2809** button.

**OR**

Select another part or link of the enrollment pages, and the record will automatically be saved.

---

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

---



## New Enrollee SF 2809 Part B

The SF 2809 Part B page is used to document the event and date details that enable the participant to enroll. This is a continuation from the SF 2809 Part A page for the enrollment. The following pages display different fields based on the Public Law selected on Part A:

For more information see:

For Public Law, TCC, Former Spouse and Child .....	37
For Public Law, Temporary Continuation of Coverage (TCC) .....	39
For Public Law, Department of Defense separated under the Reduction in Force (DOD-RIF) .....	40
For Public Law, Annuitants .....	41
For Public Law, Annuitants - Surviving Spouse or Child(ren).....	43
For Public Law, Affordable Care Act (ACA) .....	44

### ***For Public Law, TCC, Former Spouse and Child***

On any of the SF2809 pages, select the **Part B** link to complete the enrollment for registration. The SF2809 Part B page is displayed based on **Public Law TCC - Former Spouse and Child**.

Figure 12: SF2809 Part B Page, TCC Public Law - Former Spouse and Child



**For Public Law TCC - Former Spouse and Child:**

1. Complete the SF2809 Part B - Former Spouse and Child fields as follows:

---

Note: Required fields are marked with an asterisk.

---

*Event Code* (see "*Event Code Field Description*" on page 93)

*Action Effective Date* (see "*Action Effective Date Field Instruction*" on page 89)

*Separation/Event Date* (see "*Separation/Event Date Field Instruction*" on page 99)

*Signature Date* (see "*Signature Date Field Instruction*" on page 100)

*SSN* (see "*SSN Field Instruction*" on page 100)

*DOB* (see "*DOB Field Instruction*" on page 92)

*First Name* (see "*First Name Field Instruction*" on page 94)

*Middle Initial* (see "*Middle Initial Field Instruction*" on page 96)

*Last Name* (see "*Last Name Field Instruction*" on page 95)

*Account Type* (see "*Account Type Field Instruction*" on page 89)

*Claim Number* (see "*Claim Number Field Instruction*" on page 90)

*REMARKS* (see "*REMARKS Field Instruction*" on page 99)

2. After completing the fields, select the **Save** button.

**OR**

Select one of the four parts of the enrollment pages, and the record will automatically be saved.

---

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

---



## For Public Law, Temporary Continuation of Coverage (TCC)

On any of the SF 2809 pages, select the **Part B** link to complete the enrollment for registration. The SF2809 Part B page is displayed based on **Public Law TCC - Self**.

Figure 13: SF2809 Part B Page, TCC Public Law - Self

### For Public Law TCC - Self:

1. Complete the SF2809 Part B - TCC Self fields as follows:

*Event Code* (see "*Event Code Field Description*" on page 93)

*Event Date* (see "*Event Date Field Instruction*" on page 93)

*Separation Date* (see "*Separation Date Field Instruction*" on page 99)

*Last Date of Pay Period* (see "*Last Date of Pay Period Field Instruction*" on page 94)

*Signature Date* (see "*Signature Date Field Instruction*" on page 100)

*REMARKS* (see "*REMARKS Field Instruction*" on page 99)

2. After completing the fields, select the **Save** button.

**OR**

Select one of the four parts of the enrollment pages, and the record will automatically be saved.

---

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

---



## For Public Law, Department of Defense separated under the Reduction in Force (DOD-RIF)

On any of the SF 2809 pages, select the **Part B** link to complete the enrollment for registration. The SF2809 Part B page is displayed based on **Public Law, DOD-RIF**.

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**SF2809 Part B**

[Part A](#) [Part C](#)

**Enrollee Name:** John Doe    **Enrollee SSN:** XXXXXXXXX

<b>Event That Permits You To Enroll</b>		Event Code	Event Date
Separation Date	Last Date of Pay Period	4A	<input type="text"/> <input type="button" value="B3"/>
<input type="text"/> <input type="button" value="B3"/>	<input type="text"/> <input type="button" value="B3"/>	Signature Date*	Number Hours (DOD Only)
<input type="text"/> <input type="button" value="B3"/>	<input type="text"/> <input type="button" value="B3"/>	<input type="text"/> <input type="button" value="B3"/>	080 <input type="text"/>
DOD Component	DOD Activity	DOD Location	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
REMARKS		<input type="text"/>	

Figure 14: SF2809 Part B Page, DOD-RIF Public Law

### For Public Law, DOD-RIF:

1. Complete the SF2809 Part B - DOD-RIF fields as follows:

**Event Code** (see "**Event Code Field Description**" on page 93)

**Event Date** (see "**Event Date Field Instruction**" on page 93)

**Separation Date** (see "**Separation Date Field Instruction**" on page 99)

**Last Date of Pay Period** (see "**Last Date of Pay Period Field Instruction**" on page 94)

**Signature** (see "**Signature Field Instruction**" on page 100)

**Date** (see "**Date Field Instruction**" on page 91)

**Number Hours (DOD Only)** (see "**Number Hours (DOD Only) Field Instruction**" on page 96)

**DOD Component** (see "**DOD Component Field Instruction**" on page 92)

**DOD Activity** (see "**DOD Activity Field Instruction**" on page 92)





**DOD Location** (see "**DOD Location Field Instruction**" on page 92)

**REMARKS** (see "**REMARKS Field Instruction**" on page 99)

2. After completing the fields, select the **Save** button.

**OR**

Select one of the four parts of the enrollment pages, and the record will automatically be saved.

---

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

---

### **For Public Law, Annuitants**

On any of the SF 2809 pages, select the **Part B** link to complete the enrollment for registration. The SF2809 Part B page is displayed based on **Public Law, Annuitant**.

Figure 15: SF2809 Part B Page, Annuitant Public Law

#### **For Public Law, Annuitant:**

1. Complete the SF2809 Part B - Annuitants fields as follows:

---

Note: Required fields are marked with an asterisk.

---

**Event Code** (see "**Event Code Field Description**" on page 93)



*Action Effective Date* (see "*Action Effective Date Field Instruction*" on page 89)

*Separation/Event Date* (see "*Separation/Event Date Field Instruction*" on page 99)

*Signature Date* (see "*Signature Date Field Instruction*" on page 100)

*Account Type* (see "*Account Type Field Instruction*" on page 89)

*Claim Number* (see "*Claim Number Field Instruction*" on page 90)

*REMARKS* (see "*REMARKS Field Instruction*" on page 99)

2. After completing the fields, select the **Save** button.

**OR**

Select one of the four parts of the enrollment pages, and the record will automatically be saved.

---

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

---



## For Public Law, Annuitants - Surviving Spouse or Child(ren)

On any of the SF 2809 pages, select the **Part B** link to complete the enrollment for registration. The SF2809 Part B page is displayed based on **Public Law, Annuitant - Surviving Spouse or Child(ren)**.

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SF2809 Part B

Part A Part C Save Back

Enrollee Name: John Doe Enrollee SSN: XXXXXXXX

Event Code Action Effective Date

Event That Permits You To Enroll

2M

Separation/Event Date Signature Date\*

Original Employee Information

SSN DOB

First Name Middle Initial Last Name

Account Type Claim Number

REMARKS

Figure 16: SF2809 Part B Page, Annuitant Public Law - Surviving Spouse or Child(ren)

### For Public Law, Annuitant - Surviving Spouse or Child(ren):

1. Complete the SF2809 Part B - Annuitants - Surviving Spouse or Child(ren) fields as follows:

**Event Code** (see "**Event Code Field Description**" on page 93)

**Action Effective Date** (see "**Action Effective Date Field Instruction**" on page 89)

**Separation/Event Date** (see "**Separation/Event Date Field Instruction**" on page 99)

**Signature Date** (see "**Signature Date Field Instruction**" on page 100)

**SSN** (see "**SSN Field Instruction**" on page 100)

**DOB** (see "**DOB Field Instruction**" on page 92)

**First Name** (see "**First Name Field Instruction**" on page 94)

**Middle Initial** (see "**Middle Initial Field Instruction**" on page 96)



**Last Name** (see "**Last Name Field Instruction**" on page 95)

**Account Type** (see "**Account Type Field Instruction**" on page 89)

**Claim Number** (see "**Claim Number Field Instruction**" on page 90)

**REMARKS** (see "**REMARKS Field Instruction**" on page 99)

2. After completing the fields, select the **Save** button.

**OR**

Select one of the four parts of the enrollment pages, and the record will automatically be saved.

---

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

---

### **For Public Law, Affordable Care Act (ACA)**

On any of the SF 2809 pages, select the **Part B** link to complete the enrollment for registration. The SF2809 Part B page is displayed based on **Public Law, ACA**.

The screenshot shows the SF2809 Part B page for ACA Public Law. The page has a blue header with navigation links: HOME, DPRS, REPORTS, and LOGOUT. The main content area is white with a blue border. It contains the following fields and controls:

- Buttons: Part A, Part C, Save, Back
- Enrollee Name: John Doe
- Enrollee SSN: XXXXXXXXXX
- Event That Permits You To Enroll: HA (in a dropdown menu)
- Event Code: HA (in a text box)
- Event Date: (in a date picker)
- Separation Date: (in a date picker)
- Last Date of Pay Period: (in a date picker)
- Signature Date: (in a date picker)
- REMARKS: (in a text area)

Figure 17: SF2809 Part B Page, ACA Public Law

### **For Public Law, ACA:**

1. Complete the SF2809 Part B - ACA fields as follows:

**Event Code** (see "**Event Code Field Description**" on page 93)



***Event Date*** (see "***Home Phone Field Instruction***" on page 94)

***Separation Date*** (see "***Separation Date Field Instruction***" on page 99)

***Last Date of Pay Period*** (see "***Last Date of Pay Period Field Instruction***" on page 94)

***Signature Date*** (see "***Signature Date Field Instruction***" on page 100)

***REMARKS*** (see "***REMARKS Field Instruction***" on page 99)

2. After completing the fields, select the **Save** button.

**OR**

Select one of the four parts of the enrollment pages, and the record will automatically be saved.

---

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

---



## New Enrollee SF 2809 Part C

The SF 2809 Part C page contains information on the payroll and submitting office and certifies the enrollment. An enrollment will not be sent to NFC for processing until it is certified.

### To Certify the SF 2809:

1. On any of the SF 2809 pages, select the **Part C** link to complete the required fields for enrollment. The SF2809 Part C page is displayed.

The screenshot shows the SF2809 Part C page with the following fields and values:

- Enrollee Name:** sondra smith
- Enrollee SSN:** XXXXXXXXXXX
- Date Received \*:** 08-13-2013
- Effective Date \*:** 07-16-2013
- Personnel Phone Number \*:** XXXXXXXXXXX
- Name of Agency/Retirement System \*:** hrssc benefits and compe
- Address \*:** p o box 111
- City \*:** City
- State \*:** State
- Zip \*:** XXXXX
- Payroll Office Number \*:** 18000009
- Payroll Contact First Name \*:** payroll
- Payroll Contact Last Name \*:** contact
- Payroll Phone Number \*:** XXXXXXXXXXX

Buttons: [Part A](#), [Part B](#), [Save](#), [Back](#)

Links: [LOGOUT](#), [I Certify This SF2809](#), [If you would like to enter another enrollment click here](#)

**Certifying Official**

First Name	Last Name	UserID	Date Of Certification

Figure 18: SF2809 Part C Page

2. Complete the SF 2809 Part C-Enrollee Information fields as follows:

Note: Required fields are marked with an asterisk.

***Date Received*** (see "***Date Received Field Instruction***" on page 91)

***Effective Date*** (see "***Effective Date Field Description***" on page 93)



**Personnel Phone Number** (see "**Personnel Phone Number Field Instruction**" on page 98)

**Name of Agency/Retirement System** (see "**Name of Agency/Retirement System Field Instruction**" on page 96)

**Address** (see "**Address Field Instruction**" on page 89)

**City** (see "**City Field Instruction**" on page 90)

**State** (see "**State Field Instruction**" on page 101)

**Zip** (see "**Zip Field Instruction**" on page 101)

**Payroll Office Number** (see "**Payroll Office Number Field Instruction**" on page 97)

**Payroll Contact First Name** (see "**Payroll Contact First Name Field Instruction**" on page 97)

**Payroll Contact Last Name** (see "**Payroll Contact Last Name Field Instruction**" on page 97)

**Payroll Phone Number** (see "**Payroll Phone Number Field Instruction**" on page 97)

3. After completing the fields, select the **Save** button.
4. Select the **I Certify This SF2809** button when all required fields are completed.

**OR**

To add another enrollment or SF 2809, select the **If you would like to enter another enrollment click here** link.

---

CAUTION: If the record has not been saved or certified, you will receive a warning message requesting to select **Yes** to save or **No** to cancel the action. If you select **Yes**, the record will only be saved, not certified.

---



When the user has not completed the required fields on Part A and attempts to save the record or navigate to another part or attempts to certify the record, the Certification Failed page will display a list of fields missing from the registration. All errors must be cleared before the record can be saved or certified.

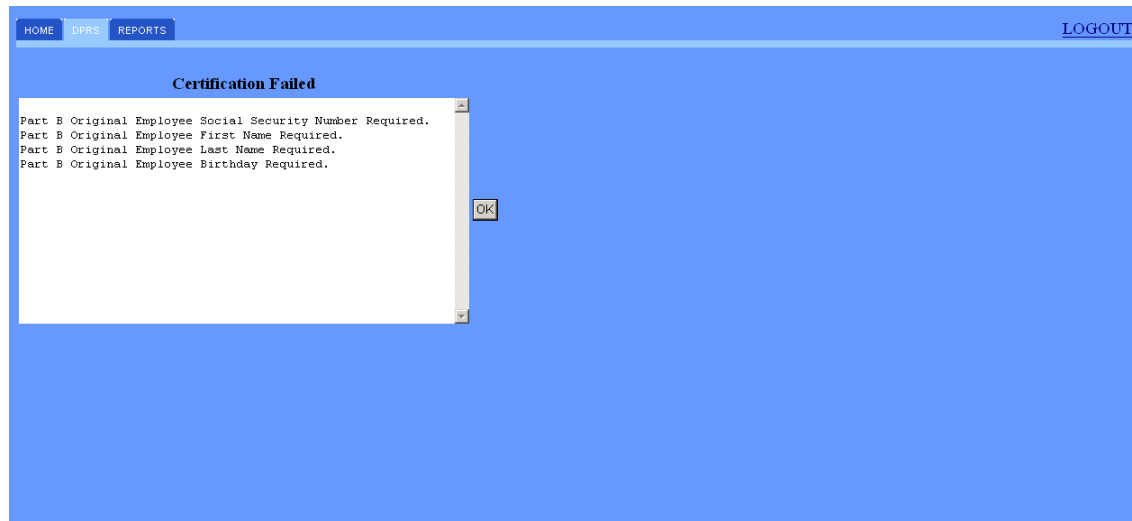


Figure 19: Certification Failed Page

5. Select the **OK** button. Select the page that is missing the required information to complete the certification.





6. After all required fields are completed, select the **I Certify This SF2809** button.

Figure 20: SF2809 Part C Page (Certifying Official)

7. The Certifying Official fields will automatically generate when the registration is certified.

The following fields will be displayed:

**First Name** (see "**First Name (Certifying Official) Field Description**" on page 94)

**Last Name** (see "**Last Name (Certifying Official) Field Description**" on page 95)

**UserID** (see "**UserID (Certifying Official) Field Description**" on page 101)

**Date of Certification** (see "**Date of Certification Field Description**" on page 91)

---

Note: If there are errors upon saving or certifying, the Certification Failed page will display. A list of the fields which are missing required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields in each part of the enrollment are completed. All errors must be cleared before the record can be saved or certified. If the record will not process, go to DPRW **HOME**, reenter the SSN, and select **Search/Complete Registration SF2809** and recertify the enrollment.



Note: All new enrollments will be picked up with the nightly batch processing. Once processed, either the new enrollment record will be created or the record will show up on the suspense report. All suspense or updates to the record will need to be made in the DPRS mainframe, by internal DPRS personnel.

---



## Search/Complete Registration SF 2809

In order to correct any registration for the original enrollee and/or dependent information, the registration cannot be certified in the mainframe. If the enrollee has been certified, follow the instructions under Corrections.

**To search/complete original enrollee and/or dependent information:**

1. On the DPRS Main Menu, enter the enrollee's SSN.

HOME DPRS REPORTS [LOGOUT](#)

**DPRS Menu**

**Enter a Social Security Number and choose a button.**

Social Security Number

---

**Enter a Name and choose Search Name button.**

First Name

Middle Initial

Last Name \*

Figure 21: DPRS Menu Page



2. Select the **Search/Complete Registration SF2809** button. The SF2809 Part A, Enrollee Information page is displayed. Only a certified official can modify the registration.

**SF2809 Part A**

Family Info Part B Part C Save SF2809 Back

**Enrollee Information**

Public Law *	Relationship To Employee *	Current Enrollment Plan	New Enrollment Plan *
100-654 - TCC	Former Spouse		104
First Name *	Middle Initial	Last Name *	Social Security Number *
Jane	C	Smith	XXXXXXXXXX
Date of Birth *	Sex *	Married *	Country Domestic
09-27-1951	Female	No	UNITED STATES Yes
Address 1 *	Address 2	City *	State * Zip *
308 Dog Rd		City	State XXXXX
* Enter at least one phone number			
Home Phone	Work Phone	Cell Phone	Email
XXXXXXXXXX			Janesmith@live.com
Other Insurance	Medicare Claim Number	Other Insurance Name	Insurance Policy Number
None			
SON Number *	2228 - DA, OFFICE OF THE ASST SECRETARY (FORT RILEY, KS)		

Figure 22: SF2809 Part A, Enrollee Information Page

3. Correct each SF 2809 page (Part A, B, C, and Family Information) of the registration as applicable.
4. Once the fields are completed and/or corrected, select the **Save SF2809** or **Save** button on each individual SF 2809 page.

Note: The Search/Complete Registration SF2809 page contains the same fields as the Add Registration SF2809 page. The SF 2809 Part A, Enrollee Information; Part B; *New Enrollee SF 2809 Part C* (on page 46); and Family Information pages of instructions can be used when completing the fields on the Search/Completed Registration SF2809 page.



## View Certified SF 2809

The View Certified SF 2809 page displays records that have been certified and processed in the nightly batch job.

---

Note: This is an NFC Operations function only.

---

### To View Certified SF2809:

1. On the DPRS Main Menu, enter the enrollee's SSN.

HOME DPRS REPORTS [LOGOUT](#)

**DPRS Menu**

**Enter a Social Security Number and choose a button.**

Social Security Number

---

**Enter a Name and choose Search Name button.**

First Name

Middle Initial

Last Name \*

Figure 23: DPRS Menu Page



2. Select the **View Certified SF2809** button. The SF2809 Part A, Enrollee Information page is displayed. Each page of the certified SF 2809 will be available for review.

HOME DPRS REPORTS [LOGOUT](#)

**SF2809 Part A**

[Family Info](#) [Part B](#) [Part C](#)

**Enrollee Information**

Public Law *	Relationship To Employee *	Current Enrollment Plan	New Enrollment Plan *	
100-654 - TCC	Former Spouse		104	
First Name *	Middle Initial	Last Name *	Social Security Number *	
Jane	C	Smith	XXXXXXXXXX	
Date of Birth *	Sex *	Married *	Country	Domestic
09-27-1951	Female	No	UNITED STATES	Yes
Address 1 *	Address 2	City *	State *	Zip *
308 Dog Rd		City	State	XXXXXX
* Enter at least one phone number				
Home Phone	Work Phone	Cell Phone	Email	
XXXXXXXXXX			Janesmith@live.com	
Other Insurance	Medicare Claim Number	Other Insurance Name	Insurance Policy Number	
None				
SON Number *				
2228 - DA, OFFICE OF THE ASST SECRETARY (FORT RILEY, KS)				

Figure 24: SF2809 Part A, Enrollee Information Page



## DPRS Reports Generated

NFC will maintain records in such a manner as to facilitate the prompt and accurate updating of accounts and summarization for financial reporting to OPM. NFC will maintain adequate controls to ensure the accuracy of the remittances by each enrollment code.

For more information see:

<b>Reports from DPRS Mainframe .....</b>	<b>55</b>
<b>Reports from DPRW .....</b>	<b>56</b>

## Reports from DPRS Mainframe

NFC will assume the responsibility for providing OPM with the following reports:

- **SF 2812** - Report of Withholdings and Contributions for Retirement, Health Benefits, and Group Life Insurance.
- **SF 2812A** - Report of Withholdings and Contributions for Health Benefits by Enrollment Code.
- **OPM 1523** - Semiannual Headcount Reporting.
- **DPRS 1501** - Report on all initial SF 2809s and SF 2810s processed in the previous month.
- **DPRS 1601** - Report indicating individual retirement record changes for the spouse equity.

NFC will assume responsibility for providing FEHB carriers with the SF 2811. At the request of an FEHB carrier, NFC will provide a magnetic tape and/or list of plan enrollees. Carriers will use the list in their reconciliation of enrollees. In the case of a discrepancy, NFC will be notified by the carrier and asked to provide the necessary documentation (normally, copies of the SF 2809 or SF 2810) to resolve the problem.

For verification purposes, NFC will provide each submitting office with a report (DPRS 1501) giving information on all initial SF 2809/SF 2810 activity processed in the previous monthly cycle. (See Exhibit VI: DPRS 1501 and 1601 Reports for an example of DPRS 1501.)

NFC will provide each submitting office with a report (DPRS 1601) indicating any changes, terminations, or cancelations in enrollment for Spouse Equity Accounts. This report should be forwarded to the retirement section of the payroll office to note on the employee's retirement master record (SF 2806-1/SF 3101) any spouse equity enrollments, cancelations, terminations, or reinstatements. (See Exhibit VI: DPRS 1501 and 1601 Reports for an example of DPRS 1601.)



## Reports from DPRW

NFC will assume the responsibility for providing OPM with the DPRS Incomplete SF2809 report which identifies all records that have been saved in DPRW but not certified.

DPRW provides an Incomplete SF2809 Report. This report identifies all records that have been saved in DPRW but not certified. A list of plan enrollees will be provided with the option to complete or delete the registration. (See DPRS Incomplete SF 2809 Report for an example.)

*Complete* (see "*Complete (Registration) Field Instruction*" on page 90)

*Delete* (see "*Delete (Registration) Field Instruction*" on page 92)

For more information see:

<b>Completing an Incomplete SF 2809 Report in DPRW.....</b>	<b>56</b>
<b>Correcting Registration in DPRW .....</b>	<b>58</b>

### **Completing an Incomplete SF 2809 Report in DPRW**

When the user selects the **Reports** option on any of the DPRW pages (see an example of the DPRS Incomplete SF 2809 Report), a reports menu page will be displayed providing a category for the incomplete SF 2809 report to be selected.

The Incomplete SF2809 Report will provide a list of individuals that are missing information to complete the registration (SSN, First Name, Last Name, Home Phone, Email, Updated By, and Date of Last Update). The report offers the option to complete or delete the individual's SF 2809. The Agencies may run this report at any time.





**To Review a Report in DPRW:**

1. Select the **Reports** tab. The Reports page is displayed.



**Figure 25: DPRS Incomplete SF2809 Report Page**

2. Select the **Incomplete SF2809 Report** link. The Incomplete SF2809 Report page is displayed.

SSN	FirstName	LastName	HomePhone	Email	Updated By	Date of Last Update	Action
XXXXXXXXXX	Sally	DICKIE	XXXXXXXXXX		NF000	3/19/2013 9:23:15 AM	Complete Delete
XXXXXXXXXX	RUSSO	RETRO	XXXXXXXXXX		NF000	1/14/2013 2:11:45 PM	Complete Delete
XXXXXXXXXX	EUGENE	EMPLOY	XXXXXXXXXX		NF000	1/11/2013 8:08:56 AM	Complete Delete
XXXXXXXXXX	KIRA	KIND			NF000	1/11/2013 8:13:02 AM	Complete Delete
XXXXXXXXXX	JESSICA	TRAINING	XXXXXXXXXX		NF000	1/15/2013 2:33:36 PM	Complete Delete
XXXXXXXXXX	JEFFERY	MANDATORY	XXXXXXXXXX		NF000	1/16/2013 10:19:47 AM	Complete Delete
XXXXXXXXXX	STEVEN	SEPARATION	XXXXXXXXXX		NF000	1/3/2013 12:00:00 AM	Complete Delete
XXXXXXXXXX	lilian	lilly	XXXXXXXXXX			1/3/2013 12:00:00 AM	Complete Delete
XXXXXXXXXX	MICHAEL	MANDEVILLE	XXXXXXXXXX		NF000	1/3/2013 12:00:00 AM	Complete Delete
XXXXXXXXXX	RICHARD	RETIREMENT	XXXXXXXXXX		NF000	1/14/2013 2:56:14 PM	Complete Delete
XXXXXXXXXX	jane	doe	XXXXXXXXXX			2/21/2013 2:08:46 PM	Complete Delete
XXXXXXXXXX	Darryl	DEBT	XXXXXXXXXX			2/8/2013 12:28:57 PM	Complete Delete
XXXXXXXXXX	Transfer	Test	XXXXXXXXXX		NF000	3/11/2013 10:21:29 AM	Complete Delete
XXXXXXXXXX	Jennifer	MONEY	XXXXXXXXXX		NF000	2/5/2013 12:02:04 PM	Complete Delete
XXXXXXXXXX	Sally	John			NF000	2/21/2013 8:14:54 AM	Complete Delete
XXXXXXXXXX	Jill	Jack	XXXXXXXXXX		NF000	2/21/2013 8:15:17 AM	Complete Delete
XXXXXXXXXX	SUNG	SANG	XXXXXXXXXX		NF000	2/21/2013 8:49:16 AM	Complete Delete

**Figure 26: Incomplete SF2809 Report Page**

3. Select the **Complete** button to update the record and complete the registration.



**OR**

Select the **Delete** button if the enrollee needs to be removed from DPRW.

4. To exit the report, select the applicable DPRW page.

**OR**

Select the **Back** button on the Incomplete SF2809 Report page.

### ***Correcting Registration in DPRW***

The following information is provided for Agencies to make corrections. If the initial SF 2809 or SF 2810 is incorrectly prepared in DPRW and has not been certified, Agencies must go to the correct registration to make the appropriate correction and certify.

#### **To Correct Registration in DPRW:**

1. On the DPRS Main Menu, enter the enrollee's Social Security Number.

HOME DPRS REPORTS [LOGOUT](#)

**DPRS Menu**

**Enter a Social Security Number and choose a button.**

Social Security Number

---

**Enter a Name and choose Search Name button.**

First Name

Middle Initial

Last Name \*

**Figure 27: DPRS Menu Page**



2. Select the **Correct Registration SF2809** button. The SF2809 Part A, Enrollee Information page is displayed. Only a certified official can modify the registration.

**Figure 28: SF2809 Part A, Enrollee Information Page**

3. Correct each individual SF2809 page (Part A, B, C, and Family Information) of the registration as applicable.
4. Once the fields are corrected, select the **Save SF2809** or **Save** button on each individual SF 2809 page.

---

Note: The Correct Registration SF2809 page contains the same fields as the Add Registration SF2809 page. The SF2809 Part A, Enrollee Information; Part B; *New Enrollee SF 2809 Part C* (on page 46); and Family Information pages of instructions can be used when completing the fields on the Search/Completed Registration SF2809 page.

---





## Forms and Reports

Forms and reports that are associated with DPRS activities are provided with examples on the different enrollments.

This section includes the following topics:

<b>SF 2809, Health Benefits Election Form .....</b>	<b>61</b>
<b>SF 2810, Notice of Change in Health Benefits Enrollment .....</b>	<b>65</b>
<b>SF 2809, Types of New Enrollments .....</b>	<b>67</b>
<b>SF 2810 and Original SF 2809 for Transfer Enrollees.....</b>	<b>74</b>
<b>SF 2809 and SF 2810 for Corrections .....</b>	<b>76</b>
<b>DPRS 1501 and 1601 Reports .....</b>	<b>80</b>
<b>DPRS Incomplete SF 2809 Report.....</b>	<b>80</b>
<b>Submitting Transfers and Corrections .....</b>	<b>83</b>

### SF 2809, Health Benefits Election Form

This topic has been updated to replace SF 2809 with the latest version. The Medicare Claim Number field has been changed to Medicare Beneficiary Identifier.



See *Appendix II, Instructions on Completing the SF 2809<sup>1</sup>* for detailed instructions on completing SF 2809.

---

<sup>1</sup> SF 2809, Health Benefits Election FormPart A - Enrollee and Family Member's InformationFieldDescription/InstructionEnrollee nameEnter last, first, and middle initial.Social Security NumberEnter Social Security number (SSN).Separated employee, child, or ex-spouse's SSN.Date of birthEnter Date of Birth (mm/dd/yyyy).Separated employee, child, or ex-spouse's date of birth (Month, Day, and Year).SexCheck the appropriate block (M - Male or F - Female).Are you married?Check the appropriate block (Y ...



Form Approved  
 OMB No. 3208-0160

### 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)		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. A <input type="checkbox"/> B <input type="checkbox"/> D		8. Medicare Beneficiary Identifier			
				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 Name of other insurance: _____ Policy Number: _____ <input type="checkbox"/> FEHB An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.									
11. Email address					12. Preferred telephone number				
13. Name of family member (last, first, middle initial)		14. Social Security Number		15. Date of birth (mm/dd/yyyy)		16. Sex <input type="checkbox"/> M <input type="checkbox"/> F		17. Relationship code	
18. Address (if different from enrollee)				19. If this family member is covered by Medicare, check all that apply. A <input type="checkbox"/> B <input type="checkbox"/> D		20. Medicare Beneficiary Identifier			
				21. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 22 below. <input type="checkbox"/> No					
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.									
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)		26. Social Security Number		27. Date of birth (mm/dd/yyyy)		28. Sex <input type="checkbox"/> M <input type="checkbox"/> F		29. Relationship code	
30. Address (if different from enrollee)				31. If this family member is covered by Medicare, check all that apply. A <input type="checkbox"/> B <input type="checkbox"/> D		32. Medicare Beneficiary Identifier			
				33. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 34 below. <input type="checkbox"/> No					
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.									
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)		38. Social Security Number		39. Date of birth (mm/dd/yyyy)		40. Sex <input type="checkbox"/> M <input type="checkbox"/> F		41. Relationship code	
42. Address (if different from enrollee)				43. If this family member is covered by Medicare, check all that apply. A <input type="checkbox"/> B <input type="checkbox"/> D		44. Medicare Beneficiary Identifier			
				45. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 46 below. <input type="checkbox"/> No					
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.									
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)

Standard Form 2809  
 Revised November 2019

U.S. Office of Personnel Management

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

Enrollee name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

1. Plan name \_\_\_\_\_ 2. Enrollment code \_\_\_\_\_

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

1. Plan name \_\_\_\_\_ 2. Enrollment code \_\_\_\_\_

**Part D - Event That Permits You To Enroll, Change, or Cancel** (see page 6)

1. Event code \_\_\_\_\_ 2. Date of event \_\_\_\_\_

**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** (Annuitants/Formers 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.

**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) \_\_\_\_\_

2. Date (mm/dd/yyyy) \_\_\_\_\_

Part I - To be completed by agency or retirement system



**Figure 29: Standard Form 2809, Health Benefits Election Form**





## SF 2810, Notice of Change in Health Benefits Enrollment

See Appendix III, Instructions on Completing the SF 2810, for the instructions on completing the SF 2810 form.


 Federal Employees Health Benefits Program		<b>Notice of Change in Health Benefits Enrollment</b>	
<b>Part A - Identifying Information</b>			
1. Name (Last, first, middle initial)		2. Date of birth	3. Social security number
4. Home address (including ZIP Code)		5. Payroll office number	6. Enrollment code number
		7. SF 2811 Report number	8. Date this action becomes effective
Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.			
<b>Part B - Termination</b>			
Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date. <i>Important Notice: You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.</i>			
If termination is due to death of enrollee enter date of death		Date of death (mo, dy, yr)	
<b>Part C - Transfer In</b>		<b>Part D - Reinstatement</b>	
The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.		Your enrollment has been reinstated effective on the date in Part A, item 8, above.	
<b>Part E - Change in Name of Enrollee</b>		<b>Part F - Change In Enrollment-Survivor Annuitant</b>	
The name under which this enrollment is carried has been changed to:		Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)	
Name	Date of Birth	New Enrollment Code Number <input style="width: 100px;" type="text"/>	
Address (including ZIP Code) if different from Part A, item 4, above.			
<b>Part G - Remarks</b>			
<b>Part H - Date of Notice</b>			
<i>Note: Instructions for Employing Offices are on the back of Copy 4 of this form.</i>			
Name and address of agency (including ZIP Code)		Personnel contact and telephone number	
		Payroll contact and telephone number	
Signature of authorized agency official			Date
U.S. Office of Personnel Management CSRS/FERS Handbook for Personnel and Payroll Offices		NSN 7540-01-232-1234 Copy 1 - To Enrollee	Previous edition is usable 2810-104 Standard Form 2810 Revised June 1995

Figure 30: SF 2810, FEHB Notice of Change in Health Benefits Enrollment (Part A)



## Part B - Termination

*If Part B on the other side of this form is checked, read the following instructions carefully.*

### 31-Day Extension of Coverage

Your enrollment terminates on the date shown in Part A, item 8, on the front of this form. Coverage under your enrollment continues temporarily for 31 days from the date shown. If you, or any covered member of your family, are a patient in a hospital on the 31st day of this temporary extension, benefits of the plan may continue for the rest of that confinement, but not beyond 60 more days.

### Conversion to Nongroup Contract

You may convert your enrollment to a nongroup contract, without evidence of good health. The nongroup contract to which you may convert is one regularly offered by your plan. It may differ from your group plan in benefits, or cost, or both, and you will have to pay the entire cost of the nongroup contract directly to the plan. The nongroup contract is effective on the day after your 31-day extension of coverage ends.

If you are interested in converting to a nongroup contract, write for information to the nearest office of the plan in which you have been enrolled (see the plan's brochure or ask your employing office for the address of the plan's nearest office). The plan will promptly send you an application form and details concerning benefits and rates of the nongroup contract to which you may convert.

### Time Limit on Conversion

Normally, to be eligible for conversion, you must send your written request for information to your plan within 31 days after the date shown in Part H. However, if the date shown in Part H is more than 60 days after the date your enrollment terminates (Part A, item 8), you must forward it to your plan within 91 days after the date shown in Part A, item 8.

If you are prevented by causes beyond your control from submitting a timely request for information about conversion to a nongroup contract, you should write to your plan as soon as possible asking approval of a belated conversion opportunity. Explain fully the circumstances that

prevented earlier action and attach proof of the loss of group coverage (e.g., Standard Form 50 terminating Federal employment). A plan may consider requests filed within 6 months after group eligibility ends. If your plan needs assistance in processing your request, it should contact OPM.

### Temporary Continuation of Coverage

If you are an employee whose enrollment is terminating because you are separating from service (including separation for retirement), you may be eligible to temporarily continue your benefits coverage under the Federal Employees Health Benefits Program after separation. Within 61 days after the date shown in Part A, item 8, on the front of this form, your employing office will formally notify you of your rights regarding temporary continuation of coverage and tell you where you may obtain additional information. You will have 60 days after the later of (1) your date of separation from service, or (2) the date you receive the notice from your employing office in which to elect temporary continuation of coverage.

When your temporary continuation of coverage expires, you will be entitled to the 31-day extension of coverage and the opportunity to convert to a nongroup contract.

### Entry on Active Military Duty

If you elected to terminate your enrollment because you are entering military service, you may convert to a nongroup contract even though your family members are entitled to care under the Uniformed Services Health Benefits Program. If you return to civilian duty in the exercise of reemployment rights, your enrollment will be reinstated effective on the day you return to active duty. If you return to civilian duty not in the exercise of reemployment rights, you must, if eligible for coverage, register again the same as a new employee. If you are an annuitant, your enrollment will be reinstated on the day you are separated from military service. You must notify your retirement system of this event by furnishing a copy of your separation papers.

## Part C - Transfer of Enrollment

*If Part C on the other side of this form is checked, read carefully whichever of the following instructions applies:*

### Transfer of Employment

Your enrollment has been transferred from your previous agency or payroll office to the agency or payroll office shown in Part H. If you are in a prepaid comprehensive medical plan and you left the area served by the plan, you may be able to change to another plan. For details about your right to change plans, check with your employing office.

### Retirement

Your enrollment has been transferred from your employing agency to the retirement system shown in Part H. Your enrollment continues automatically during retirement if you retire on an immediate annuity and you have been enrolled under the Federal Employees Health Benefits Program for the lesser of (1) all your service since your first opportunity to enroll, or (2) the 5 years of service immediately preceding retirement. Your share of the cost of your enrollment will be withheld from your annuity.

### Death

The enrollment of the deceased employee named in Part A has been transferred to the retirement system shown in Part H. If the deceased employee or annuitant was enrolled for self and family at the time of death, and if at least one member of the family is entitled to a survivor annuity (or the widow(er) is entitled to the Basic Employee Death Benefits under FERS), coverage for each family member who was covered by the employee's enrollment continues automatically.

If there is only one eligible survivor, the enrollment will be changed from family coverage to self only. The survivor's share of the cost of the enrollment will be deducted from the annuity. Application for Death Benefits (Standard Form 2800 or the equivalent) should be filed promptly to avoid any question about health benefits coverage. When the survivor annuity is approved, another form like this one will be issued to show that the enrollment is being continued in the survivor's name.

### Employees' Compensation

Your enrollment has been transferred to the Office of Workers' Compensation Programs. Your enrollment continues automatically while you receive monthly compensation from the Office of Workers' Compensation Programs if the Secretary of Labor has held that you are unable to return to duty and if you have been enrolled under the Federal Employees Health Benefits Program for the lesser of (1) all your service since your first opportunity to enroll, or (2) the 5 years of service immediately preceding the start of your compensation. Enrollment of covered family members of a deceased employee or compensation also continues automatically while they receive monthly compensation, if (1) the deceased employee or compensation was enrolled for self and family at the time of death, and (2) at least one of the covered family members is entitled to compensation as a surviving beneficiary under the Federal Employees' Compensation Act. The compensation's or survivor's share of the cost of the enrollment will be deducted from the compensation checks.

**Keep This Form For Your Records**

Back, Copy 1  
Standard Form 2810  
Revised June 1995

Figure 31: SF 2810, FEHB Notice of Change in Health Benefits Enrollment (Part B)



## SF 2809, Types of New Enrollments

This topic has been updated to replace SF 2809 with the latest version. The Medicare Claim Number field has been changed to Medicare Beneficiary Identifier.



### New enrollment under the Spouse Equity law.


		Form Approved OMB No. 5206-0160		
Federal Employees Health Benefits Program		<b>Health Benefits Election Form</b>		
<b>Part A - Enrollee and Family Member Information (for additional family members use a separate sheet and attach)</b>				
1. Enrollee name (last, first, middle initial) <b>Enrollees Name</b>	2. Social Security Number <b>XXX-XX-XXXX</b>	3. Date of birth (mm/dd/yyyy) <b>XX/XX/XXXX</b>	4. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	5. Are you married? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6. Home mailing address (including ZIP Code) <b>Enrollees Address</b>		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 Beneficiary Identifier
City/State/ZIP		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 Name of other insurance: _____ Policy Number: _____ <input type="checkbox"/> FEHB An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.				
11. Email address		12. Preferred telephone number		
13. Name of family member (last, first, middle initial)	14. Social Security Number	15. Date of birth (mm/dd/yyyy)	16. Sex <input type="checkbox"/> M <input type="checkbox"/> F	17. Relationship code
18. Address (if different from enrollee)		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 Beneficiary Identifier
		21. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 22 below. <input type="checkbox"/> No		
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.				
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)	26. Social Security Number	27. Date of birth (mm/dd/yyyy)	28. Sex <input type="checkbox"/> M <input type="checkbox"/> F	29. Relationship code
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 Beneficiary Identifier
		33. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 34 below. <input type="checkbox"/> No		
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.				
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)	38. Social Security Number	39. Date of birth (mm/dd/yyyy)	40. Sex <input type="checkbox"/> M <input type="checkbox"/> F	41. Relationship code
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 Beneficiary Identifier
		45. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 46 below. <input type="checkbox"/> No		
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.				
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)				
U.S. Office of Personnel Management		For agency distribution of copies, see page 5 of the instructions.		Standard Form 2809 Revised November 2019

Figure 32: SF 2809, FEHB Health Benefits Election Form Spouse Equity Law



## Equation 2: SF 2809, FEHB Health Benefits Election Form, Under the Spouse Equity Law (Part B)

<b>Part B - FEHB Plan You Are Currently Enrolled In (if applicable)</b>		<b>Part C - FEHB Plan You Are Enrolling In or Changing To</b>	
1. Plan name <b>BCBS</b>	2. Enrollment code <b>104</b>	1. Plan name	2. Enrollment code
<b>Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2)</b>		<b>Part E - Election NOT to Enroll (Employees Only)</b>	
1. Event code <b>3A</b>	2. Date of event <b>XX / XX XXXX</b>	<input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
<b>Part F - Cancellation of FEHB</b>		<b>Part G - Suspension of FEHB (Annuitants/Former Spouses Only)</b>	
<input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		<input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
<b>Part H - Signature</b>			
<p><i>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.)</i></p>			
1. Your signature (do not print) <b>Enrollee's Signature</b>		2. Date (mm/dd/yyyy) <b>XX / XX / XXXX</b>	
3. Email address <b>Enrollee's email address</b>		4. Preferred telephone number <b>( XXX ) XXX-XXXX</b>	
<b>Part I - To be completed by agency or retirement system</b>			
<b>SON 0119</b>		<b>Original Employee: First Name, Last Name</b>	
<b>Exspouse: P.L.98-615 (5USL 890.5a)</b>		<b>SSN: XXX-XX-XXXX</b>	
		<b>DOB: XX/XX/XXXX</b>	
1. Date received (mm/dd/yyyy) <b>XX/XX/XXXX</b>	2. Effective date of action (mm/dd/yyyy) <b>XX/XX/XXXX</b>	3. Personnel telephone number <b>( XXX ) XXX-XXXX</b>	
4. Name and address of agency or retirement system <b>Agency Name</b>		5. Authorizing official (please print) <b>Authorized Official's Name</b>	
<b>Agency Address</b> City/State/ZIP		6. Signature of authorized agency official <b>Authorized Official's Signature</b>	
7. Payroll office number <b>XX XX XXXX</b>	8. Payroll office contact (please print) <b>Name of a Payroll's contact</b>	9. Payroll telephone number <b>( XXX ) XXX-XXXX</b>	




<b>Part B - FEHB Plan You Are Currently Enrolled In (if applicable)</b>		<b>Part C - FEHB Plan You Are Enrolling In or Changing To</b>	
1. Plan name <b>BCBS</b>	2. Enrollment code <b>104</b>	1. Plan name	2. Enrollment code
<b>Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2)</b>		<b>Part E - Election NOT to Enroll (Employees Only)</b>	
1. Event code <b>3A</b>	2. Date of event <b>XX / XX XXXX</b>	<input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
<b>Part F - Cancellation of FEHB</b>		<b>Part G - Suspension of FEHB (Annuitants/Former Spouses Only)</b>	
<input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		<input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
<b>Part H - Signature</b>			
<i>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.)</i>			
1. Your signature (do not print) <b>Enrollee's Signature</b>		2. Date (mm/dd/yyyy) <b>XX / XX / XXXX</b>	
3. Email address <b>Enrollee's email address</b>		4. Preferred telephone number <b>( XXX ) XXX-XXXX</b>	
<b>Part I - To be completed by agency or retirement system</b>			
<b>SON 0119</b>		<b>Original Employee: First Name, Last Name</b>	
<b>Exspouse: P.L.98-615 (5USL 890.5a)</b>		<b>SSN: XXX-XX-XXXX</b>	
		<b>DOB: XX/XX/XXXX</b>	
1. Date received (mm/dd/yyyy) <b>XX/XX/XXXX</b>	2. Effective date of action (mm/dd/yyyy) <b>XX/XX/XXXX</b>	3. Personnel telephone number <b>( XXX ) XXX-XXXX</b>	
4. Name and address of agency or retirement system <b>Agency Name</b>		5. Authorizing official (please print) <b>Authorized Official's Name</b>	
6. Signature of authorized agency official <b>Agency Address</b> <b>City/State/ZIP</b>		6. Signature of authorized agency official <b>Authorized Official's Signature</b>	
7. Payroll office number <b>XX XX XXXX</b>	8. Payroll office contact (please print) <b>Name of a Payroll's contact</b>	9. Payroll telephone number <b>( XXX ) XXX-XXXX</b>	

Standard Form 2809  
Reverse of revised August 2011  
Previous edition is not usable

Figure 33: SF 2809, FEHB Health Benefits Election Form, Under the Spouse Equity Law (Part B)



**New enrollment under the TCC law.**

 Federal Employees Health Benefits Program		<b>Health Benefits Election Form</b>			Form Approved OMB No. 3208-0160
<b>Part A - Enrollee and Family Member Information (for additional family members use a separate sheet and attach)</b>					
1. Enrollee name (last, first, middle initial) <b>Enrollees Name</b>		2. Social Security Number <b>XXX-XX-XXXX</b>	3. Date of birth (mm/dd/yyyy) <b>XX/XX/XXXX</b>	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) <b>Enrollees Address</b>		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 Beneficiary Identifier
City/State/ZIP		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 Name of other insurance: _____ Policy Number: _____ <input type="checkbox"/> FEHB An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
11. Email address		12. Preferred telephone number			
13. Name of family member (last, first, middle initial) <b>Family Member Name</b>		14. Social Security Number <b>XXX-XX-XXXX</b>	15. Date of birth (mm/dd/yyyy) <b>XX/XX/XXXX</b>	16. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	17. Relationship code <b>01</b>
18. Address (if different from enrollee)		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 Beneficiary Identifier
		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			
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
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) <b>Family Member Name</b>		26. Social Security Number <b>XXX-XX-XXXX</b>	27. Date of birth (mm/dd/yyyy) <b>XX/XX/XXXX</b>	28. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	29. Relationship code <b>19</b>
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 Beneficiary Identifier
		33. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 34 below. <input type="checkbox"/> No			
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
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)		38. Social Security Number	39. Date of birth (mm/dd/yyyy)	40. Sex <input type="checkbox"/> M <input type="checkbox"/> F	41. Relationship code
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 Beneficiary Identifier
		45. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 46 below. <input type="checkbox"/> No			
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
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)			

**Figure 34: SF 2809, FEHB Health Benefits Election Form, Under the TCC Law (Part A)**



<b>Part B - FEHB Plan You Are Currently Enrolled In (if applicable)</b> 1. Plan name 2. Enrollment code		<b>Part C - FEHB Plan You Are Enrolling In or Changing To</b> 1. Plan name <b>Kaiser</b> 2. Enrollment code <b>E35</b>	
<b>Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2)</b> 1. Event code <b>4A</b> 2. Date of event <b>XX / XX XXXX</b>		<b>Part E - Election NOT to Enroll (Employees Only)</b> <input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
<b>Part F - Cancellation of FEHB</b> <input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		<b>Part G - Suspension of FEHB (Annuitants/Former Spouses Only)</b> <input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
<b>Part H - Signature</b> <i>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.)</i>			
1. Your signature (do not print) <b>Enrollee's Signature</b>		2. Date (mm/dd/yyyy) <b>XX / XX / XXXX</b>	
3. Email address <b>Enrollee's email address</b>		4. Preferred telephone number <b>( XXX ) XXX-XXXX</b>	
<b>Part I - To be completed by agency or retirement system</b> <small>DEM/DFC</small> <b>Self: P.L.100 - 654 (5USL 8905a); Separation: XX/XX/XXXX</b> <b>End of PPD: XX/XX/XXXX</b>			
1. Date received (mm/dd/yyyy) <b>XX/XX/XXXX</b>		2. Effective date of action (mm/dd/yyyy) <b>XX/XX/XXXX</b>	
4. Name and address of agency or retirement system <b>Agency Name</b> <b>Agency Address</b> <b>City/State/ZIP</b>		3. Personnel telephone number <b>( XXX ) XXX-XXXX</b> 5. Authorizing official (please print) <b>Authorized Official's Name</b> 6. Signature of authorized agency official <b>Authorized Official's Signature</b>	
7. Payroll office number <b>XX XX XXXX</b>		8. Payroll office contact (please print) <b>Payroll's Contact Person</b> 9. Payroll telephone number <b>( XXX ) XXX-XXXX</b>	


Standard Form 2809  
Reverse of revised August 2011  
Previous edition is not usable

Figure 35: SF 2809, FEHB Health Benefits Election Form, Under the TCC Law (Part B)





**New enrollment under the DOD-RIF law.**

 Federal Employees Health Benefits Program		<b>Health Benefits Election Form</b>			Form Approved OMB No. 3208-0160
<b>Part A - Enrollee and Family Member Information (for additional family members use a separate sheet and attach)</b>					
1. Enrollee name (last, first, middle initial) <b>Enrollees Name</b>		2. Social Security Number <b>XXX-XX-XXXX</b>	3. Date of birth (mm/dd/yyyy) <b>XX/XX/XXXX</b>	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) <b>Enrollees Address</b>		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 Beneficiary Identifier
City/State/ZIP		9. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 10 below. <input checked="" type="checkbox"/> No			
10. 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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
11. Email address		12. Preferred telephone number			
13. Name of family member (last, first, middle initial)		14. Social Security Number	15. Date of birth (mm/dd/yyyy)	16. Sex <input type="checkbox"/> M <input type="checkbox"/> F	17. Relationship code
18. Address (if different from enrollee)		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 Beneficiary Identifier
		21. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 22 below. <input type="checkbox"/> No			
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
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)		26. Social Security Number	27. Date of birth (mm/dd/yyyy)	28. Sex <input type="checkbox"/> M <input type="checkbox"/> F	29. Relationship code
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 Beneficiary Identifier
		33. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 34 below. <input type="checkbox"/> No			
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
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)		38. Social Security Number	39. Date of birth (mm/dd/yyyy)	40. Sex <input type="checkbox"/> M <input type="checkbox"/> F	41. Relationship code
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 Beneficiary Identifier
		45. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 46 below. <input type="checkbox"/> No			
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
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)					
U.S. Office of Personnel Management		For agency distribution of copies, see page 5 of the instructions.		Standard Form 2809 Revised November 2019	

**Figure 36: SF 2809, FEHB Health Benefits Election Form, Under the DOD-RIF Law (Part A)**



<b>Part B - FEHB Plan You Are Currently Enrolled In (if applicable)</b>		<b>Part C - FEHB Plan You Are Enrolling In or Changing To</b>	
1. Plan name	2. Enrollment code	1. Plan name <b>BCBS</b>	2. Enrollment code <b>111</b>
<b>Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2)</b>		<b>Part E - Election NOT to Enroll (Employees Only)</b>	
1. Event code <b>4A</b>	2. Date of event <b>XX / XX XXXX</b>	<input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
<b>Part F - Cancellation of FEHB</b>		<b>Part G - Suspension of FEHB (Annuitants/Former Spouses Only)</b>	
<input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		<input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
<b>Part H - Signature</b>			
<small>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.)</small>			
1. Your signature (do not print) <b>Enrollee's Signature</b>		2. Date (mm/dd/yyyy) <b>XX / XX / XXXX</b>	
3. Email address <b>Enrollee's email address</b>		4. Preferred telephone number <b>( XXX ) XXX-XXXX</b>	
<b>Part I - To be completed by agency or retirement system</b>			
<small>DEMANDS</small> <b>SON 0117</b> <b>Self: P.L.102 - 484 (5 USL 8905a (d) (4)); Separation Date: XX/XX/XXXX</b> <b>Last day of PP: XX/XX/XXXX Apprpration code: 45C 100 35530A</b> <b>Agency code: AFIS</b>			
1. Date received (mm/dd/yyyy) <b>XX/XX/XXXX</b>	2. Effective date of action (mm/dd/yyyy) <b>XX/XX/XXXX</b>	3. Personnel telephone number <b>( XXX ) XXX-XXXX</b>	
4. Name and address of agency or retirement system <b>Agency Name</b> <b>Agency Address</b> <b>City/State/ZIP</b>		5. Authorizing official (please print) <b>Authorized Official's Name</b> <b>Authorized Official's Signature</b>	
7. Payroll office number <b>XXXXX</b>	8. Payroll office contact (please print) <b>Payroll's Contact Person</b>	9. Payroll telephone number <b>( XXX ) XXX-XXXX</b>	

Figure 37: SF 2809, FEHB Health Benefits Election Form, Under the DOD-RIF Law (Part B)


## SF 2810 and Original SF 2809 for Transfer Enrollees

To transfer out of Employment, Retirement, Death, and Employees' Compensation, the following forms are required:

- SF 2810, Notice of Change in Health Benefits Enrollment
- SF 2809, Health Benefits Election Form (Original)



**Transfer Out**

 <b>Notice of Change in Health Benefits Enrollment</b>		
<b>Part A - Identifying Information</b>		
1. Name (Last, First, middle initial) <b>Enrollees Name</b>	2. Date of birth XX/XX/XXXX	3. Social security number XXX-XX-XXXX
4. Home address (including ZIP Code) <b>Enrollees Address</b> City/State/Zip	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number XX/XX/XXXX	8. Date this action becomes effective XXX
Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.		
<b>Part B - Termination</b>		
Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date. <b>Important Notice:</b> You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage. If termination is due to death of enrollee enter date of death		
	Date of death (mo, dy, yr)	
<b>Part C - Transfer In</b>		<b>Part D - Reinstatement</b>
The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.		Your enrollment has been reinstated effective on the date in Part A, item 8, above.
<b>Part E - Change in Name of Enrollee</b>		<b>Part F - Change in Enrollment-Survivor Annuitant</b>
The name under which this enrollment is carried has been changed to: Name _____ Date of Birth _____ Address (including ZIP Code) if different from Part A, item 4, above.		Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)  New Enrollment Code Number <input type="text"/>
<b>Part G - Remarks</b>		
Transfer Out - National Finance Center Direct Premium Remittance System		
<b>Part H - Date of Notice</b>		
<i>Note: Instructions for Employing Offices are on the back of Copy 4 of this form.</i>		
Name and address of agency (include ZIP Code) Agency Address City/State/ZIP		Personal contact and telephone number Authorized Official & Phone Number _____ Personal contact and telephone number Authorized Agency Official & Phone Number _____
Signature of authorized agency official <b>Must Have Signature</b>		Date XX/XX/XXXX
U.S. Office of Personnel Management, 2025 E Street, NW, Washington, DC 20535-1204, 2010-104, Previous edition is obsolete, Standard Form 2810, Revised June 1995		

**Figure 38: SF 2810, FEHB Notice of Change in Health Benefits Enrollment (Transfer Out)**

Note: The Agencies need to include the original SF 2809, Health Benefits Election Form. The Agencies must verify the address and phone number on the original SF 2809 for accuracy.



## **SF 2809 and SF 2810 for Corrections**

This topic has been updated to replace SF 2809 and SF 2810 with the latest version. The Medicare Claim Number field has been changed to Medicare Beneficiary Identifier.



If an incorrect action was processed, the personnel office should send a corrected SF 2809 or SF 2810 to NFC indicating the erroneous information in the Remarks block. The SF 2809 or SF 2810 must be clearly labeled "CORRECTION."


 Federal Employees Health Benefits Program		Health Benefits Election Form			Form Approved OMB No. 3206-0160
<b>Part A - Enrollee and Family Member Information (for additional family members use a separate sheet and attach)</b>					
1. Enrollee name (last, first, middle initial) <b>Enrollees Name</b>		2. Social Security Number XXX-XX-XXXX	3. Date of birth (mm/dd/yyyy) XX/XX/XXXX	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) <b>Enrollees Address</b>		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 Beneficiary Identifier	
City/State/ZIP		9. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 10 below. <input checked="" type="checkbox"/> No			
10. 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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
11. Email address			12. Preferred telephone number		
13. Name of family member (last, first, middle initial)		14. Social Security Number	15. Date of birth (mm/dd/yyyy)	16. Sex <input type="checkbox"/> M <input type="checkbox"/> F	17. Relationship code
18. Address (if different from enrollee)		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 Beneficiary Identifier	
21. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 22 below. <input type="checkbox"/> No					
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
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)		26. Social Security Number	27. Date of birth (mm/dd/yyyy)	28. Sex <input type="checkbox"/> M <input type="checkbox"/> F	29. Relationship code
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 Beneficiary Identifier	
33. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 34 below. <input type="checkbox"/> No					
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
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)		38. Social Security Number	39. Date of birth (mm/dd/yyyy)	40. Sex <input type="checkbox"/> M <input type="checkbox"/> F	41. Relationship code
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 Beneficiary Identifier	
45. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 46 below. <input type="checkbox"/> No					
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 Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
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)		

Figure 39: SF 2809, FEHB Health Benefits Election Form (Part A Correction)



<b>Part B - FEHB Plan You Are Currently Enrolled In (if applicable)</b> 1. Plan name 2. Enrollment code		<b>Part C - FEHB Plan You Are Enrolling In or Changing To</b> 1. Plan name 2. Enrollment code	
		Blue Cross/Blue Shields 104	
<b>Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2)</b> 1. Event code 2. Date of event		<b>Part E - Election NOT to Enroll (Employees Only)</b> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
3A      XX/XX/XXXX			
<b>Part F - Cancellation of FEHB</b> <input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		<b>Part G - Suspension of FEHB (Annuitants/Former Spouses Only)</b> <input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
<b>Part H - Signature</b> 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) Enrollees Signature		2. Date (mm/dd/yyyy) XX/XX/XXXX	
3. Email address Enrollees Email Address		4. Preferred telephone number (XXX) XXX-XXXX	
<b>Part I - To be completed by agency or retirement system</b> PER/PRC			
CORRECTION: DOB from: XXXXXXXX to: XXXXXXXX on Ex-spouse P.L. 98-615 Original Employee Name, SSN XXX-XX-XXXX, DOB XXXXXXXX			
1. Date received (mm/dd/yyyy) XXXXXXXX	2. Effective date of action (mm/dd/yyyy) XXXXXXXX	3. Personnel telephone number XXX XXX-XXXX	
4. Name and address of agency or retirement system Agency Name Agency Address City/State/ZIP		5. Authorizing official (please print) Authorized Agency Official Name	
		6. Signature of authorized agency official Must Be signed	
7. Payroll office number	8. Payroll office contact (please print)	9. Payroll telephone number	

Figure 40: SF 2809, FEHB Health Benefits Election Form (Part B Correction)



OR


 Federal Employees Health Benefits Program		<b>Notice of Change in Health Benefits Enrollment</b>	
<b>Part A - Identifying Information</b>			
1. Name (Last, first, middle initial) Enrollees Name		2. Date of birth XX/XX/XXXX	3. Social security number XXX-XX-XXXX
4. Home address (including ZIP Code) Enrollees Address City/State/ZIP		5. Pavroll office number 104	6. Enrollment code number 104
		7. SF 2811 Report number	8. Date this action becomes effective XX/XX/XXXX
Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.			
<b>Part B - Termination</b>			
Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date. <b>Important Notice:</b> You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage. If termination is due to death of enrollee enter date of death			
		Date of death (mo, dy, yr)	
<b>Part C - Transfer In</b>		<b>Part D - Reinstatement</b>	
<input type="checkbox"/> The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.		<input type="checkbox"/> Your enrollment has been reinstated effective on the date in Part A, item 8, above.	
<b>Part E - Change in Name of Enrollee</b>		<b>Part F - Change In Enrollment-Survivor Annuitant</b>	
<input type="checkbox"/> The name under which this enrollment is carried has been changed to: Name _____ Date of Birth _____ Address (including ZIP Code) if different from Part A, item 4, above.		<input type="checkbox"/> Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)  New Enrollment Code Number <input style="width: 100px; border: 1px solid black;" type="text"/>	
<b>Part G - Remarks</b>			
CORRECTION: DOB from: XX/XX/XXXX to: XX/XX/XXXX on Ex-spouse P.L. 98-615 Original Employee Name, SSN XXX-XX-XXXX, DOB XX/XX/XXXX			
<b>Part H - Date of Notice</b>			
Note: Instructions for Employing Offices are on the back of Copy 4 of this form.			
Name and address of agency (including ZIP Code) Agency Name _____ Agency Address _____ City/State/ZIP _____		Personnel contact and telephone number Authorized Official's Name _____ (XXX)XXX-XXXX  Pavroll contact and telephone number Authorized Agency Official _____ (XXX)XXX-XXXX	
Signature of authorized agency official Must be Signed by Authorized Agency Official _____		Date XX/XX/XXXX	
U.S. Office of Personnel Management CSRS/FERS Handbook for Personnel and Payroll Offices		NSN 7540-01-232-1234 Copy 1 - To Enrollee 2810-104 Previous edition is usable Standard Form 2810 Revised June 1995	

Figure 41: SF2809 FEHB Correction



## DPRS 1501 and 1601 Reports

### DPRS 1501

DPRS 1501, Report of SF2809s and SF2810s Processed for the Month of XXXX, provides a list of SF 2809s and SF 2810s processed for the month ACCT No. (Account Number), Enrollee Name, FEHB (Federal Employee Health Benefit) Plan, ACT TKN (Action Taken), Received, Processed, Effective Dates, Evnt (Event) Code, Expire Date, AD (Add Department), Law, and Relationship.

REPORT DPRS1501		USDA-NFC				PAGE: 3		
DATE PREPARED XX/XX/XXXX		DIRECT PREMIUM REMITTANCE SYSTEM				SENSITIVE PERSONNEL DATA		
TIME PREPARED 20:16		SF2809S AND SF2810S PROCESSED				USE IS RESTRICTED		
DEPT LL SON 0107		FOR THE MONTH OF OCTOBER 2013 XXXXXXXXXX DOE, JANE D						
ACCT NO.	ENROLLEE NAME	FEHB ACT	*-----SF2809/SF2810 DATES-----*	EVNT	EXPIRE	PLAN TKN	RECEIVED PROCESSED EFFECTIVE CODE DATE AD	LAW RELATIONSHIP
XXXXXXXX	DOE, JANE D	314	ENR 10/01/2013 10/23/2013	10/02/2013	4A	02/02/2015	D	2 SELF
XXXXXXXX	TRAINER, SALLY Y	111	ENR 10/01/2013 10/23/2013	10/02/2013	4A	02/28/2015	D	2 SELF
XXXXXXXX	WEB, MAIN F	111	ENR 10/24/2013 10/30/2013	10/01/2013	4A	02/28/2015	D	2 SELF
XXXXXXXX	SNAGIT, ED	112	ENR 09/25/2013 10/25/2013	09/01/2013	4A	01/31/2015	D	2 SELF
XXXXXXXX	EDIT, DREW	311	ENR 09/22/2013 10/24/2013	08/01/2013	4A	12/04/2014	D	2 SELF
XXXXXXXX	REVIEW, TECH	F84	ENR 09/30/2013 10/25/2013	10/01/2013	4A	02/06/2015	D	2 SELF
XXXXXXXX	PAY, DAY M	E34	ENR 09/30/2013 10/25/2013	10/01/2013	4A	02/16/2015	D	2 SELF

Figure 42: USDA - NFC, Direct Premium Remittance System, SF2809s and SF2810s Processed for the Month of XXXX 20XX

### DPRS 1601

DPRS 1601, Individual Retirement Record Changes for Spouse Equity, provides a list of individual retirement record changes for the spouse equity (Former Spouse: Name, ACCT No. (Account Number), and Birth Date; Original Employee: Name, ACCT No. (Account Number), Birth Date; Effective Date; and Action Taken).

REPORT DPRS1601		USDA-NFC				PAGE: 3	
DATE PREPARED XX/XX/XXXX		DIRECT PREMIUM REMITTANCE SYSTEM				SENSITIVE PERSONNEL DATA	
TIME PREPARED 18:10		INDIVIDUAL RETIREMENT RECORD CHANGES FOR SPOUSE EQUITY				USE IS RESTRICTED	
DEPT:HE SON:1166		XXXXXXXXXX TO XXXX/XXXX					
NOTE: THIS REPORT SHOULD BE FORWARDED TO THE RETIREMENT SECTION OF THE PAYROLL OFFICE TO ANNOTATE ON THE ORIGINAL EMPLOYEES RETIREMENT MASTER RECORD (SF-2806/SF-3100) OR SUPPLEMENTAL RECORD (SF-2806-1/SF-3101) ANY SPOUSE EQUITY ENROLLMENTS, CANCELLATIONS, TERMINATIONS, OR REINSTATEMENTS IN ACCORDANCE WITH FPM SUPPLEMENT 890-1, CHAPTER 17.							
* - - - - - FORMER SPOUSE - - - - - *							
NAME	ACCT NO.	BIRTHDATE					
TRAINER, TRAIN T	XXXXXXXXXX	XXXXXXXXXX					
* - - - - - ORIGINAL EMPLOYEE - - - - - *							
NAME	ACCT NO.	BIRTHDATE	EFFECTIVE DATE	ACTION TAKEN			
TRAINER, TRAIN T	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	CAN			

Figure 43: USDA - NFC, Direct Premium Remittance System, Individual Retirement Record Changes for Spouse Equity XX/XX/XXXX To XX/XX/XXXX

## DPRS Incomplete SF 2809 Report

### DPRS Incomplete SF2809

DPRW provides an Incomplete SF2809 Report. This report identifies all records that have been saved in DPRW but not certified. A list of plan enrollees will be provided with the option to





complete or delete the registration. The DPRS Incomplete SF2809 Report may be run at any time.

SSN	FirstName	LastName	HomePhone	Email	Updated By	Date of Last Update	Action	
XXXXXXXXXX	Sally	DICKIE	XXXXXXXXXX		NF000	3/19/2013 9:23:15 AM	Complete	Delete
XXXXXXXXXX	RUSSO	RETRO	XXXXXXXXXX		NF000	1/14/2013 2:11:45 PM	Complete	Delete
XXXXXXXXXX	EUGENE	EMPLOY	XXXXXXXXXX		NF000	1/11/2013 8:08:56 AM	Complete	Delete
XXXXXXXXXX	KIRA	KIND			NF000	1/11/2013 8:13:02 AM	Complete	Delete
XXXXXXXXXX	JESSICA	TRAINING	XXXXXXXXXX		NF000	1/15/2013 2:33:36 PM	Complete	Delete
XXXXXXXXXX	JEFFERY	MANDATORY	XXXXXXXXXX		NF000	1/16/2013 10:19:47 AM	Complete	Delete
XXXXXXXXXX	STEVEN	SEPARATION	XXXXXXXXXX		NF000	1/3/2013 12:00:00 AM	Complete	Delete
XXXXXXXXXX	lilian	lilly	XXXXXXXXXX			1/3/2013 12:00:00 AM	Complete	Delete
XXXXXXXXXX	MICHAEL	MANDEVILLE	XXXXXXXXXX		NF000	1/3/2013 12:00:00 AM	Complete	Delete
XXXXXXXXXX	RICHARD	RETIREMENT	XXXXXXXXXX		NF000	1/14/2013 2:56:14 PM	Complete	Delete
XXXXXXXXXX	jane	doe	XXXXXXXXXX			2/21/2013 2:08:46 PM	Complete	Delete
XXXXXXXXXX	Darryl	DEBT	XXXXXXXXXX			2/8/2013 12:28:57 PM	Complete	Delete
XXXXXXXXXX	Transfer	Test	XXXXXXXXXX		NF000	3/11/2013 10:21:29 AM	Complete	Delete
XXXXXXXXXX	Jennifer	MONEY	XXXXXXXXXX		NF000	2/5/2013 12:02:04 PM	Complete	Delete
XXXXXXXXXX	Sally	John			NF000	2/21/2013 8:14:54 AM	Complete	Delete
XXXXXXXXXX	Jill	Jack	XXXXXXXXXX		NF000	2/21/2013 8:15:17 AM	Complete	Delete
XXXXXXXXXX	SUNG	SANG	XXXXXXXXXX		NF000	2/21/2013 8:49:16 AM	Complete	Delete

Figure 44: DPRS Incomplete SF2809 Report Page





## Submitting Transfers and Corrections

Agencies must follow the existing DPRS process when transferring or correcting an existing account. The transfer/correction process in DPRW will be phased in at later date.

HR Agencies and OPM will mail/fax all SF 2809s and SF 2810s for transfers and corrections to NFC for processing. Once received, NFC Operations reviews the forms and returns any incomplete or inaccurate forms back to the Agency. All complete forms are then entered by the NFC Operations staff into DPRS. After the nightly processing, either a new enrollment record or a suspense record is created in DPRS. NFC Operations reviews and clears all suspense in DPRS.

Send all completed forms and/or files to:

USDA, National Finance Center  
DPRS Billing Unit  
P.O. Box 61760  
New Orleans, Louisiana 70161-1760

**OR**

Fax to:

1-303-274-3805

This section includes the following topics:

<b>Transfers</b> .....	<b>83</b>
<b>Corrections</b> .....	<b>84</b>

### ***Transfers***

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NOTE: Agencies must follow the existing DPRS process when transferring an existing account. The transfer process in DPRW will be phased in at a later date.

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Agencies that are maintaining existing P.L. 98-615 and P.L. 100-654 (5 U.S.C. 8905a) accounts within their own systems may transfer those accounts to NFC. (Do not transfer an employee when they separate from your employment. These employees should be terminated and then submitted to NFC as a new enrollment.)

When transferring an existing account, conversion of billing from the original Agency to NFC must be coordinated. Agencies should call the DPRS Billing Unit at NFC at **1-800-242-9630** for more information.

Agencies will prepare, process, and distribute an SF 2810 documenting the transfer out of the Agencies' DPRS processing to NFC. In addition to the SF 2810, Agencies will provide NFC with the Official Personnel File (OPF) copy of the initialed SF 2809. See an example of the ***SF 2810***



**and Original SF 2809 for Transfer Enrollees** (on page 74). For instructions on filling out the SF 2810, see Appendix III, Instructions on Completing the SF 2810. P.L. 98-615 enrollee health benefits files should be sent to NFC under a separate cover sheet. Agencies should verify the address and phone number on the SF 2809 for accuracy.

Based on receipt of these forms from the Agencies, NFC will prepare SF 2810s to transfer in the enrollees and will establish an account for each enrollee involved in the transfer. No active accounts with an overdue premium should be transferred into NFC until the overdue amount has been collected.

Send the completed forms to:

USDA, National Finance Center  
DPRS Billing Unit  
P.O. Box 61760  
New Orleans, Louisiana 70161-1760

### **To Transfer Existing Accounts**

- **Agencies:**
  - Prepare SF 2810 and establish each transferred enrollee in to DPRS.
  - Forward copies of SF 2810, OPF, and initialed SF 2809 to NFC.
- **NFC:**
  - Generate SF 2810 copy to FEHB carrier.
  - Forward enrollee coupon book for making payments through lock box.
  - Monitor enrollee accounts.
  - Provide reporting to OPM and carrier.

### **Corrections**

---

Note: Agencies must follow the existing DPRS process when correcting an existing account. The transfer process in DPRW will be phased in a later date.

---

In order to correct any registration for the original enrollee and/or dependent information, the registration cannot be certified in the mainframe. If the enrollee has been certified, follow the instructions below.

1. Correction processing is necessary when the erroneous information given on the SF 2809 or the SF 2810 affects a person's entitlement (e.g., errors in enrollee's name, SSN, family members, enrollment code, effective date, or similar errors). Depending on the type of error and who became aware of it, NFC either receives a completed SF 2809 or SF 2810 from the Agency for processing or NFC prepares and processes an SF 2809 or SF 2810 to correct the error. The SF 2809 or SF 2810 must be clearly labeled "correction," must



- include the enrollee's name and SSN; and should show the items to be corrected. The forms are processed and copies distributed as described in the appropriate sections above. Also, NFC will send each affected carrier the appropriate copy of the corrected SF 2809.
2. If the incorrect action was processed, the personnel office should send a corrected SF 2809 or SF 2810 to NFC indicating the erroneous information in the remarks field. (See SF 2809 and SF 2810 for corrections.) The enrollee's copy should be sent to the enrollee. NFC will perform the necessary actions to "void" the SF 2809 or SF 2810 action that was erroneously processed. NFC will generate the respective carrier's copy (under cover of the SF 2811, Transmittal and Summary Report to Carrier).

#### **Responsibilities to Change/Cancel/Terminate an Enrollment**

- **Enrollee** - Prepare SF 2809 and forward to NFC.
- **NFC** - Process or generate SF 2809/SF 2810 to accomplish change, cancelation, or termination.





## Field Instructions

This section will provide the instructions or a description for each field listed in the DPRS application.

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## Account Type Field Instruction

### Account Type

For survivor annuitants, select the appropriate account.

- Annuitant
- Surviving Spouse
- Surviving Spouses/Child(ren)
- Surviving Child(ren)
- Disabled Child(ren)

---

Note: If the Account Type is for Surviving Spouse, Surviving Spouse/Child(ren), Surviving Child(ren), or Disabled Child(ren), additional fields will display to enter in the Federal employee's/annuitant's information.

---

## Action Effective Date Field Instruction

### Action Effective Date

Select the calendar icon for the date which the enrollment will be effective. Each down arrow displays a list; select the correct year, month, and date.

---

Note: Only the calendar icon can be used to enter dates. Must select year and month, then select a calendar date. It is important that you follow the order; otherwise the calendar will automatically go back to the current date.

---

## Add Registration SF2809 Field Instruction

### Add Registration SF2809

New enrollees - establish enrollment of a child of a current employee, enrollment of a separated employee, and initial enrollment of former spouse of current employee.

## Address Field Instruction

### Address

Enter the address of the Department to be contacted for information related to the request for action.

## Address 1 Field Instruction

### Address 1



Enter the enrollee's residence address, number, and street name.

## **Address 2 Field Instruction**

### **Address 2**

Enter a second line of address information, if applicable.

## **Cell Phone Field Instruction**

### **Cell Phone**

Enter the telephone number beginning with the area code for the individual to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.

## **City Field Instruction**

### **City**

Enter the name of the city of the enrollee's residence address.

## **Claim Number Field Instruction**

### **Claim Number**

Type in the OPM-provided claim number beginning with an A or F.

## **Complete (Registration) Field Instruction**

### **Complete (Registration)**

Opens the record for editing and completion.

## **Confirm New Password Field Instruction**

### **Confirm new password**

Retype your new password to verify the password that you entered in the Enter new password field. Your password is not displayed on the page. Validate the entry for correctness.

## **Correct Registration SF2809 Field Instruction**

### **Correct Registration SF2809**

Make corrections to a new enrollee's registration before the enrollment is processed or generated.



## Country Field Instruction

### Country

Defaults to **United States**. For a different country, select the down arrow to display the list and select the appropriate country.

## Current Enrollment Plan Field Instruction

### Current Enrollment Plan

Enter the enrollment plan that the enrollee is currently enrolled in.

## Date Field Instruction

### Date of Birth Field Instruction

#### Date of Birth

Select the calendar icon for the Federal employee's/annuitant's date of birth. Each down arrow displays a list; select the correct year, month, and date.

---

Note: Only the calendar icon can be used to enter dates. Must select year and month, then select calendar date. It is important that you follow the order; otherwise the calendar will automatically go back to the current date.

---

### Date of Certification Field Description

#### Date of Certification

Date the enrollment was certified.

### Date Received Field Instruction

#### Date Received

Select the calendar icon to enter the date the Agency received the SF 2809. Each down arrow displays a list; select the correct year, month, and date.

---

Note: Only the calendar icon can be used to enter dates. Must select year and month, then select calendar date. It is important that you follow the order; otherwise the calendar will automatically go back to the current date.

---



## Delete (Registration) Field Instruction

### Delete (Registration)

Deletes the uncertified record.

## Delete Field Instruction

### Delete

Select the **Delete** button next to the appropriate dependent. To confirm the deletion, select the **OK** button.

## DOB Field Instruction

### DOB

Select the calendar icon for the Federal employee's/annuitant's date of birth. Each down arrow displays a list; select the correct year, month, and date.

---

Note: Only the calendar icon can be used to enter dates. Must select year and month, then select calendar date. It is important that you follow the order; otherwise the calendar will automatically go back to the current date.

---

## DOD Activity Field Instruction

### DOD Activity

Enter the specific activity for which the Federal employee worked.

## DOD Component Field Instruction

### DOD Component

Enter the component within DOD for which the Federal employee worked.

## DOD Location Field Instruction

### DOD Location

Enter the numeric location.

## Domestic Field Instruction

### Domestic

Defaults to **Yes**. If not domestic, select the down arrow to display the list and select **No**.



## Edit Field Instruction

### **Edit**

Select the **Edit** button, the current information will populate in the Family Information page. Update the information in the fields as needed and select the **Update Family** button.

## Effective Date Field Description

### **Effective Date**

Automatically generates the effective date based on the separation and last day of the pay period.

## Email Field Instruction

### **Email**

Enter the email address for the individual to be contacted for information related to the request for action.

---

Note: This field is optional.

---

## Enter New Password Field Instruction

### **Enter new password**

Type your new password. Your password is not displayed on the page.

## Event Code Field Description

### **Event Code**

Populates based on the Public Law selected on Part A.

## Event Date Field Instruction

### **Event Date**

Select the calendar icon for the date that the enrollee signed the SF 2809. Each down arrow displays a list; select the correct year, month, and date.

---

Note: Only the calendar icon can be used to enter dates. Must select year and month, then select calendar date. It is important that you follow the order; otherwise the calendar will automatically go back to the current date.

---



## First Name (Certifying Official) Field Description

### First Name (Certifying Official)

First name of the authorized Agency official.

## First Name Field Instruction

### First Name

Enter the Federal employee's/annuitant's first name. If the employee has two or more first names or initials (e.g., John Paul or JP) and each is to be shown, use a space to separate the two names. Do not include titles, such as Mr., Mrs., Ms., Dr., or Prof., as part of the name.

---

Note: This field is limited to 15 characters.

---

## Home Phone Field Instruction

### Home Phone

Enter the telephone number beginning with the area code for the individual to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.

## Insurance Policy Number Field Instruction

### Insurance Policy Number

If another health insurance has been listed, the health insurance policy number must be entered in this field.

---

Note: The policy number can be found on the enrollee's health insurance card.

---

## Last Date of Pay Period Field Instruction

### Last Date of Pay Period

Select the calendar icon for the last day of the pay period the enrollee's separation date descended in. Each down arrow displays a list; select the correct year, month, and date.

---

Note: Only the calendar icon can be used to enter dates. You must select year and month, then select calendar date. It is important that you follow the order; otherwise, the calendar will automatically go back to the current date.

---



## Last Name (Certifying Official) Field Description

### Last Name (Certifying Official)

Last name of the authorized Agency official.

## Last Name Field Instruction

### Last Name

Enter the Federal employee's/annuitant's last name. Enter items such as Jr., Sr., or III, with one space after the last name. If more than one space is entered, the additional item will not print on the SF 50B, Notice of Personnel Action.

If the employee has a two-part last name (e.g., Smith Martin), use a space to separate the two parts.

Do not use any type of punctuation (e.g., hyphen, period) in any part of the name.

A space counts as one character. For long names, ask the employee to provide an abbreviation.

---

Note: This field is limited to 20 characters.

---

## Married Field Instruction

### Married

Select the down arrow to select the marital status.

Valid values are:

- **Yes**
- **No**

---

Note: If the enrollee is separated but not divorced, they are still married.

---

## Medicare Claim Number Field Instruction

### Medicare Claim Number

If Medicare has been selected, the Medicare Beneficiary Identifier must be entered in this field.

---

Note: The claim number can be found on the enrollee's Medicare card.

---



## Middle Initial Field Instruction

### Middle Initial

Enter the Federal employee's/annuitant's middle initial. If the employee has two or more middle names or initials (e.g., Ann Marie or AM) and each is to be shown, use a space to separate the two names or initials. Leave the middle name blank if the employee has no middle name or initial.

## Name of Agency/Retirement System Field Instruction

### Name of Agency/Retirement System

Enter the four-position alpha acronym of the Department the individual is stationed with.

## New Enrollment Plan Field Instruction

### New Enrollment Plan

Enter the enrollment plan code for the FEHB plan requested by the enrollee.

## Number Hours (DOD Only) Field Instruction

### Number Hours (DOD Only)

Verify the number of hours for the employee's tour of duty. This field defaults to **080**.

## Other Insurance Field Instruction

### Other Insurance

Defaults to **None**. If the enrollee has other insurance, select the down arrow to display the list and select the appropriate type.

Valid values are:

- **None** - Default
- **Medicare A**
- **Medicare B**
- **Medicare D**
- **Tricare**
- **FEHB**
- **Other**





---

Note: If the enrollee has Medicare, select which part (**A**, **B**, or **D**) including prescription drug coverage under Medicare Part D.

---

## Other Insurance Name Field Instruction

### Other Insurance Name

If covered by other health insurance (either the enrollee's name or under a family member's policy), enter the insurance name.

## Password Field Instruction

### Password Field Instruction

Type your DPRS password.

## Payroll Contact First Name Field Instruction

### Payroll Contact First Name

Enter the first name of the authorized Agency Official.

---

Note: This field is limited to 15 characters.

---

## Payroll Contact Last Name Field Instruction

### Payroll Contact Last Name

Enter the last name of the Authorized Agency Official.

---

Note: This field is limited to 20 characters.

---

## Payroll Office Number Field Instruction

### Payroll Office Number

Enter the telephone number beginning with the area code for the Department to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.

## Payroll Phone Number Field Instruction

### Payroll Phone Number



Enter the telephone number beginning with the area code for the payroll office to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.

## Personnel Phone Number Field Instruction

### Personnel Phone Number

Enter the telephone number beginning with the area code for the Personnel Office to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.

## Public Law Field Instruction

### Public Law

Select the down arrow to display the list and select the correct category. Each category is designated by a number, which identifies the enrollee group.

Valid values are:

- 98-615 - Spouse Equity
- 100-654 - Temporary Continuation of Coverage (TCC)
- 102-484 - Dept of Defense (DOD) Reduction in Force System (RIF)
- 101-303 - Annuitants
- 111-5 - ACA

---

Note: For guidelines on the laws to which the Agency can process each category, refer to Appendix I, Public Laws Guidelines.

---

## Relationship Field Instruction

### Relationship

Select the down arrow to display the list and select the relationship of the eligible separated employee.

Valid values are:

- Self
- Former Spouse
- Child



## Relationship To Employee Field Instruction

### Relationship To Employee

Select the down arrow to display the list and select the relationship of the eligible separated employee.

Valid values are:

- **Self**
- **Former Spouse**
- **Child**

## REMARKS Field Instruction

### REMARKS

Enter any additional information.

## Search/Complete Registration SF2809 Field Instruction

### Search/Complete Registration SF2809

Search original enrollee and/or dependent information.

## Separation Date Field Instruction

### Separation Date

Select the calendar icon for the date that the Federal employee was separated. Each down arrow displays a list; select the correct year, month, and date.

---

Note: Only the calendar icon can be used to enter dates. Must select year and month, then select calendar date. It is important that you follow the order; otherwise the calendar will automatically go back to the current date.

---

## Separation/Event Date Field Instruction

### Separation/Event Date

Select the calendar icon for the Federal employee's/annuitant's separation/event date of the enrollee. Each down arrow displays a list; select the correct year, month, and date.

---

Note: Only the calendar icon can be used to enter dates. Must select year and month, then select calendar date. It is important that you follow the order; otherwise, the calendar will automatically go back to the current date.

---



## Sex Field Instruction

### Sex

Select the down arrow to display the list and select the appropriate sex.

*Valid values are:*

Male

Female

## Signature Field Instruction

## Signature Date Field Instruction

### Signature Date

Select the calendar icon for the date that the enrollee signed the SF 2809. Each down arrow displays a list; select the correct year, month, and date.

---

Note: Only the calendar icon can be used to enter dates. Must select year and month, then select calendar date. It is important that you follow the order; otherwise, the calendar will automatically go back to the current date.

---

## Social Security Number Field Instruction

### Social Security Number

Enter the Federal employee's/annuitant's SSN. When entering an SSN, type the nine numeric digits. Do not type dashes or hyphens.

## SON Number Field Instruction

### SON Number

Select the down arrow to display the list and select the appropriate submitting office number (SON).

## SSN Field Instruction

### SSN

Enter the Federal employee's/annuitant's SSN. When entering an SSN, type the nine numeric digits. Do not type dashes or hyphens.



## State Field Instruction

### State

Select the down arrow to display the list and select the appropriate State.

## User ID Field Instruction

### User ID Field Instruction

Type your DPRS user identification (ID).

## UserID (Certifying Official) Field Description

### UserID (Certifying Official)

Authorized Agency official's user ID that processed the request.

## View Certified SF2809 Field Instruction

### View Certified SF2809

View display of new enrollments that have been certified and processed in the nightly batch job.

---

Note: This is an NFC Operations function only.

---

## Work Phone Field Instruction

### Work Phone

Enter the telephone number beginning with the area code for the individual to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.

## Zip Field Instruction

### Zip

Enter the five-digit ZIP Code of the enrollee's address.





## Appendix

This section includes the following topics:

**Appendix I, Public Laws Guidelines.....103**  
**Appendix II, Instructions on Completing the SF 2809 .....104**  
**Appendix III, Instructions on Completing the SF 2810 .....110**

### Appendix I, Public Laws Guidelines

Law	Eligibility	Authorized to Enter Enrollment
<b>98-615 Civil Service Retirement Spouse Equity Act of 1984 (Law 1)</b>	<p>Former spouses or Federal employees or annuitants who are:</p> <p>Divorced from the employee/annuitant during their employment or receipt of annuity covered as a family member under FEHB enrollment at least 1 day during the 18 months prior to the marriage ending.</p> <hr/> <p>Note: This requirement is met when both the former spouse and the Federal employee or annuitant have FEHB enrollments.</p> <hr/> <p>Entitled to a portion of the Federal employee's annuity or to a former spouse annuity and has not remarried before reaching age 55.</p>	Agency, OPM, NFC Operations
<b>100-654 Federal Employees' Health Benefits Amendments Act of 1988 (TCC)</b>	<p>Former Federal employees who separate are eligible.</p> <p>Children of the Federal employee who lose FEHB coverage.</p> <p>Former spouses of Federal employee/annuitants who lose their status as family members.</p>	Agencies, OPM, NFC Operations
<b>101-303 Annuitants (Laws 4)</b>	<p>Federal employee/annuitants requesting to make contributions for health benefits through direct payments rather than through annuity withholdings if the annuity is insufficient to cover the required withholdings and for other purposes.</p>	OPM, NFC Operations
<b>102-484 National Defense Authorization Act for Fiscal Year 1993 (DOD RIF)</b>	<p>Department of Defense civilian employees who are involuntarily separated due to a reduction in force beginning October 23, 1992.</p>	Agencies, OPM, NFC Operations



Law	Eligibility	Authorized to Enter Enrollment
<b>111-5 American Recovery and Reinvestment Act of 2009 (Law 5)</b>	Any Federal employee who is terminated from employment involuntarily from 08/01/2009 through 05/31/2010 is eligible for the American Recovery and Reinvestment Act (ARRA) premium assistance.	Agencies, OPM, NFC Operations

## Appendix II, Instructions on Completing the SF 2809

This topic has been updated to replace the field name Medicare Claims Number with the new Medicare Beneficiary Identifier.

### SF 2809, Health Benefits Election Form Part A - Enrollee and Family Member's Information

Field	Description
<b>Enrollee name</b>	Enter last, first, and middle initial.
<b>Social Security Number</b>	Enter Social Security number (SSN). Separated employee, child, or ex-spouse's SSN.
<b>Date of birth</b>	Enter Date of Birth (mm/dd/yyyy). Separated employee, child, or ex-spouse's date of birth (Month, Day, and Year).
<b>Sex</b>	Check the appropriate block (M - Male or F - Female).
<b>Are you married?</b>	Check the appropriate block (Y - Yes or N - No).  <u>Note: If you are separated but not divorced, you are still married.</u>
<b>Home mailing address</b>	Enter enrollee's mailing address. Number, street or rural route, city, State, and ZIP Code of the separated employee, child, or ex-spouse's mailing address.
<b>If you are covered by Medicare</b>	Check all that apply (A, B, or D).
<b>Medicare Beneficiary Identifier</b>	Enter Medicare Beneficiary Identifier.  <u>Note: This number is on your Medicare card.</u>





<b>Are you covered by insurance other than Medicare?</b>	Check the appropriate block. (Yes or No. If yes, specify in item 34 below.)
<b>Indicate the type(s) of other insurance:</b>	Check all that apply (TRICARE, FEHB, or Other). FEHB - An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. Other - Enter the name of other insurance and policy number.
<b>Email address</b>	Enter enrollee's email address.
<b>Preferred telephone number</b>	Enter the enrollee's preferred telephone number.
<b>Name of family member</b>	List all eligible family members (last, first, and middle initial). Spouse must be listed first.
<b>Social Security number</b>	Enter the dependent's SSN.
<b>Date of birth</b>	Enter the dependent's date of birth (mm/dd/yyyy).
<b>Sex</b>	Check the appropriate block (M = Male or F = Female).
<b>Relationship code</b>	Enter the appropriate code as follows: <b>Relationship code</b> 01 = Spouse 19 = Child under age 26 09 = Adopted Child 17 = Stepchild 10 = 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.
<b>Address</b>	Enter the street or rural route, city, State, and ZIP Code of the separated employee, child, or ex-spouse's mailing address (number and street).



<b>If this family member is covered by Medicare</b>	Check all that apply.  <u>Note: Including prescription drug coverage under Medicare Part D.</u>
<b>Medicare Beneficiary Identifier</b>	Enter the Medicare Beneficiary Identifier.  <u>Note: This number is on your Medicare card.</u>
<b>Is this family member covered by insurance other than Medicare?</b>	Check the appropriate block. (Yes or No. If yes, specify in item 34 below.)
<b>Indicate the type(s) of other insurance</b>	Check all that apply (TRICARE, FEHB, or Other). FEHB - An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. Other - Enter the name of other insurance and policy number.
<b>Email address</b>	Enter the dependent's or enrollee's email address.
<b>Preferred telephone number</b>	Enter the dependent's or enrollee's preferred telephone number.
<b>Name of family member</b>	List all eligible family members (last, first, and middle initial). Spouse must be listed first.
<b>Social Security number</b>	Enter the dependent's SSN.
<b>Date of birth</b>	Enter the dependent's date of birth (mm/dd/yyyy).
<b>Sex</b>	Check the appropriate block (M = Male or F = Female).
<b>Relationship code</b>	Enter the appropriate code as follows:  <b>Relationship code</b> 01 = Spouse 19 = Child under age 26 09 = Adopted Child 17 = Stepchild 10 = 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.
<b>Address</b>	Enter the street or rural route, city, State, and ZIP Code of the separated employee, child, or ex-spouse's mailing address (number and street).



<b>If this family member is covered by Medicare</b>	Check all that apply.  <u>Note: Including prescription drug coverage under Medicare Part D.</u>
<b>Medicare Beneficiary Identifier</b>	Enter the Medicare Beneficiary Identifier.  <u>Note: This number is on your Medicare card.</u>
<b>Is this family member covered by insurance other than Medicare?</b>	Check the appropriate block. (Yes or No. If yes, specify in item 34 below.)
<b>Indicate the type(s) of other insurance</b>	Check all that apply (TRICARE, FEHB, or Other). FEHB - An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. Other - Enter the name of other insurance and policy number.
<b>Email address</b>	Enter the dependent's or enrollee's email address.
<b>Preferred telephone number</b>	Enter the dependent's or enrollee's preferred telephone number.
<b>Name of family member</b>	List all eligible family members (last, first, and middle initial). Spouse must be listed first.
<b>Social Security number</b>	Enter the dependent's SSN.
<b>Date of birth</b>	Enter the dependent's date of birth (mm/dd/yyyy).
<b>Sex</b>	Check the appropriate block (M = Male or F = Female).
<b>Relationship code</b>	Enter the appropriate code as follows: <b>Relationship code</b> 01= Spouse 19 = Child under age 26 09 = Adopted Child 17 = Stepchild 10 = 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.
<b>Address</b>	Enter the street or rural route, city, State, and ZIP Code of the separated employee, child, or ex-spouse's mailing address (number and street).



<b>If this family member is covered by Medicare</b>	Check all that apply.  <u>Note: Including prescription drug coverage under Medicare Part D.</u>
<b>Medicare Beneficiary Identifier</b>	Enter the Medicare Beneficiary Identifier.  <u>Note: This number is on your Medicare card.</u>
<b>Is this family member covered by insurance other than Medicare?</b>	Check the appropriate block. (Yes or No. If yes, specify in item 34 below.)
<b>Indicate the type(s) of other insurance</b>	Check all that apply (TRICARE, FEHB, or Other). FEHB - An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. Other - Enter the name of other insurance and policy number.
<b>Email address</b>	Enter the dependent's or enrollee's email address.
<b>Preferred telephone number</b>	Enter the dependent's or enrollee's preferred telephone number.

Enter the enrollee name and date of birth at the top of the page.

**Part B - FEHB Plan You Are Currently Enrolled In (If Applicable)**

Field	Description
<b>Plan name</b>	Enter the plan name.
<b>Enrollment code</b>	Enter the enrollment code.

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

Field	Description
<b>Plan name</b>	Enter the elected health benefits plan name.
<b>Enrollment code</b>	Enter the elected health benefits plan three-digit enrollment code.

**Part D - Event That Permits You to Enroll, Change, or Cancel**

Field	Description
<b>Event code</b>	Enter the event code.
<b>Date of event</b>	Enter the date of event.



---

### Part E - Election NOT to Enroll (Employees Only)

I do NOT want to enroll in the FEHB Program.

Place an "X" in the box if the enrollee wishes not to enroll in the FEHB Program.

---

Note: Signature in Part H certifies that they have read and understand the information on page 3 regarding this election.

---

### Part F - Cancellation of FEHB

I CANCEL my enrollment.

Place an "X" in the box if the enrollee wishes to cancel FEHB enrollment.

---

Note: Signature in Part H certifies that they have read and understand the information on page 3 regarding cancellation of enrollment.

---

### Part G - Suspension of FEHB (Annuitants/Former Spouses Only)

I SUSPEND my enrollment.

Place an "X" in the box if you are an annuitant or former spouse wishing to suspend your FEHB enrollment.

---

Note: Signature in Part H certifies that they have read and understand the information on page 4 regarding suspension of enrollment.

---

### Part H - Signature

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.)

Field	Description
Your signature	Sign the SF 2809 form (do not print).
Date	Enter the date the form was signed (mm/dd/yyyy).

### Part I - To Be Completed by Agency or Retirement System

Enter the appropriate remarks. Also, please enter the name and telephone number of the person completing this form in the Remarks block. Example: Form Completed by: Jane Doe, Telephone No. (123) 456-7890.

Field	Description
Date received	Enter the date received (mm/dd/yyyy).
Effective date of action	Enter the effective date of action (mm/dd/yyyy).



Field	Description
<b>Personnel telephone number</b>	Enter the Personnel telephone number.
<b>Name and address of Agency or retirement system</b>	Enter the name and address of Agency or retirement system.
<b>Authorizing official</b>	Enter the name of the Authorizing official (please print).
<b>Signature of authorized agency official</b>	Enter Signature of authorized Agency official.
<b>Payroll office number</b>	Enter the Payroll office number.
<b>Payroll office contact</b>	Enter the Payroll office contact (please print).
<b>Payroll telephone number</b>	Enter the Payroll telephone number.

## Appendix III, Instructions on Completing the SF 2810

### SF 2810, Notice of Change in Health Benefits Enrollment Part A - Identifying Information

Field	Description
<b>Name</b>	Enter the enrollee's name (Last, first, and middle initial).
<b>Date of birth</b>	Enter the date of birth (mm/dd/yyyy).
<b>Social security number</b>	Enter the enrollee's SSN.
<b>Home address</b>	Enter the enrollee's home address (including ZIP Code).
<b>Payroll office number</b>	Enter the Payroll office number.
<b>Enrollment code number</b>	Enter the enrollment code number.
<b>SF 2811 Report number</b>	Enter the SF 2811 Report number.
<b>Date this action becomes effective</b>	Enter the date this action became effective.

Note: Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form unless enrollment is terminated and applying for conversion.



### Part B - Termination

Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date. If termination is due to death of enrollee, enter date of death. Place an "X" in the box if the enrollee wishes to terminate.

### Part C - Transfer In

Place an "X" in the box if the new payroll office has accepted transfer of this enrollment.

### Part D - Reinstatement

Place an "X" in the box if enrollment has been reinstated.

### Part E - Change in Name of Enrollee

Field	Description
Name	Enter the name under which this enrollment is carried has been changed to (Last, first, and middle initial).
Date of birth	Enter the date of birth (mm/dd/yyyy).
Address	If different from Part A, item 4, above (including ZIP Code). Place an "X" in the box if name under which this enrollment is carried has been changed.

### Part F - Change in Enrollment - Survivor Annuitant

Place an "X" in the box if enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. A new enrollment code number will be issued.

### Part G - Remarks

Enter the appropriate remarks. Also, please enter the name and telephone number of the person completing this form in the Remarks block.

Example: Form Completed by: Jane Doe, Telephone No. (123) 456-7890.

### Part H - Date of Notice

Name and address of Agency	Enter the name and address of the Agency, including ZIP Code.
Personnel contact and telephone number	Enter the Personnel contact person and telephone number.



<b>Payroll contact and telephone number</b>	Enter the Payroll contact person and telephone number.
<b>Signature of authorized agency official</b>	Enter the signature of the authorized Agency official.
<b>Date</b>	Enter the date the authorized Agency official signed the form.  <u>Note: If the document is not signed, it will be returned.</u>





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