Form SF-2809 Help Guide: Health Benefits Election Form

Purpose of this Form: To enroll, make a change or cancel/waive your health benefits elections

Directions:

1. To help prevent common mistakes that often lead to paperwork rejection, follow along with the 7 checkboxes below as you complete your form.

2. All forms should be the current form from https://www.opm.gov/forms/pdf_fill/sf2809.pdf

3. Signatures on this document can be done by hand or electronically.

4. For new-hire and open season elections, you have the option to make your elections via your Employee Personnel Page (EPP)

5. After completing, deliver the form to TSA Human Capital Service Center through one of the following options

6. After completing, deliver the form using one of the following options:
   • Paper mail Address to:
     TSA HCAccess HCSC
     6363 Walker Lane, Suite 400,
     Alexandria, VA 22310
   • Email: helpdesk@hraccess-mailserver.tsa.dhs.gov
   • Fax: 1-877-872-7993

Part A) Did you remember to fill out the fields 1 through 6?

If applicable, please complete fields 7 through 10.

Did you remember to fill out at least one of the following:

• Email address

• Preferred telephone number

If enrolling into a self+one or self+family plan, the following fields are mandatory for each dependent:
• Name of family member
• SSN
• Date of Birth
• Sex
• Relationship code (see page 2, item 17 of SF-2809 instruction section)
• Address (if different from enrollee)

If applicable, please complete the following fields:
• If this family is covered by Medicare, check all that apply
  • Medicare Claim Number
• Is this family member covered by insurance other than Medicare?
  • Indicate the type of insurance
• Email address
• Preferred telephone number

☐ Part B) Did you remember to list the name and enrollment code of the FEHB you are currently enrolled in?

☐ Part C) Did you list the plan name and enrollment code you are changing to?

☐ Part D) Did you list the Event Code with the corresponding Qualifying Life Event that permits you to enroll, change, or cancel?

☐ Part E) If you wish to waive FEHB enrollment, check this box and refer to Part D.

☐ Part F) If you wish to cancel your FEHB enrollment, check this box and refer to Part D.
Part H) Did you sign and date the form? Otherwise, your submission will not be processed.

Tip) Qualifying Life Events (QLEs) are outlined in pages 6 through 8 of the instructions section of the SF-2809. There are event codes associated with each QLE and guidance on what is or is not permitted per QLE is included in the table.

You may also view the QLEs here: https://www.opm.gov/healthcare-insurance/healthcare/plan-information/changes-you-can-make-outside-of-open-season/

Please note that you must provide supporting documentation of your QLE upon submittal of your SF-2809. Failure to include documentation will result in a rejection. These forms include: marriage certificates, birth certificates, termination of coverage letters, etc.
# 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)**: [Blank]
2. **Social Security Number**: [Blank]
3. **Date of Birth (mm/dd/yyyy)**: [Blank]
4. **Sex**: [ ] Male [ ] Female
5. **Are you married?** [ ] Yes [ ] No

6. **Home mailing address (including ZIP Code)**: [Blank]

   **Street Address**: [Blank]
   **City**: [Blank]
   **State**: [Blank]
   **ZIP Code**: [Blank]

7. **If you are covered by Medicare, check all that apply**: [ ] A (Medicare) [ ] B (Medicare + Medicare Supplement) [ ] D (Medicare + Private Insurance)

8. **Are you covered by insurance other than Medicare?** [ ] Yes, indicate in item 10 below. [ ] No

9. **Other Policy Number**: [Blank]

10. **Other Name of Insurer**: [Blank]

11. **Other Policy Number**: [Blank]

12. **Other Name of Insurer**: [Blank]

## Address

13. **Complete address (if different from enrollee)**: [Blank]

14. **Social Security Number**: [Blank]

15. **Date of Birth (mm/dd/yyyy)**: [Blank]

16. **Sex**: [ ] Male [ ] Female

17. **Relationship of enrollee to enrollee**: [Blank]

18. **Name of family member (last, first, middle initial)**: [Blank]

19. **Social Security Number**: [Blank]

20. **Date of Birth (mm/dd/yyyy)**: [Blank]

21. **Sex**: [ ] Male [ ] Female

22. **Relationship to enrollee**: [Blank]

23. **Name of family member (last, first, middle initial)**: [Blank]

24. **Social Security Number**: [Blank]

25. **Date of Birth (mm/dd/yyyy)**: [Blank]

26. **Sex**: [ ] Male [ ] Female

27. **Relationship to enrollee**: [Blank]

28. **Name of family member (last, first, middle initial)**: [Blank]

29. **Social Security Number**: [Blank]

30. **Date of Birth (mm/dd/yyyy)**: [Blank]

31. **Sex**: [ ] Male [ ] Female

32. **Relationship to enrollee**: [Blank]

33. **Name of family member (last, first, middle initial)**: [Blank]

34. **Social Security Number**: [Blank]

35. **Date of Birth (mm/dd/yyyy)**: [Blank]

36. **Sex**: [ ] Male [ ] Female

37. **Relationship to enrollee**: [Blank]

38. **Name of family member (last, first, middle initial)**: [Blank]

39. **Social Security Number**: [Blank]

40. **Date of Birth (mm/dd/yyyy)**: [Blank]

41. **Sex**: [ ] Male [ ] Female

42. **Relationship to enrollee**: [Blank]

43. **Name of family member (last, first, middle initial)**: [Blank]

44. **Social Security Number**: [Blank]

45. **Date of Birth (mm/dd/yyyy)**: [Blank]

46. **Sex**: [ ] Male [ ] Female

47. **Relationship to enrollee**: [Blank]

[Continued on the reverse]
Questions about this form?

Please contact the HCAccess Help Desk by phone at 1–877–872–7990, by fax at 1-877-872-7993, or by email at this [link](https://example.com). Live agents are available 7:00 a.m. to 10:00 p.m. Eastern Standard Time (EST) Monday through Friday, excluding Federal holidays.
holidays, with additional hours for recruitment calls only from 11:00 a.m. to 3:00 p.m. EST Saturday and 12:00 p.m. to 4:00 p.m. EST Sunday.