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Phone: 1.877.TSA.7990 (1.877.872.7990)
Fax: 1.877.TSA.7993 (1.877.872.7993)

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.

FEHB
Federal Employees Health Benefits Program

Form Approved:
OMB No. 3206-0160

Health Benefits Election Form

Part A - Enrollee and Family Member Information ***(for additional family members use a separate sheet and attach)***

1. Enrollee name *(last, first, middle initial)*	2. Social Security Number	3. Date of birth *(mm/dd/yyyy)*	4. Sex	5. Are you married?
			M F	Yes No

6. Home mailing address *(including ZIP Code)*	7. If you are covered by Medicare, check all that apply.	8. Medicare Claim Number
	A B D	
	9. Are you covered by insurance other than Medicare?	
	Yes, indicate in item 10 below.	No

10. Indicate the type(s) of other insurance:

TRICARE Other *Name of other insurance:* _____ *Policy Number:* _____

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	17. Relationship code
			M F	

18. Address *(if different from enrollee)*	19. If this family member is covered by Medicare, check all that apply.	20. Medicare Claim Number
	A B D	
	21. Is this family member covered by insurance other than Medicare?	
	Yes, indicate in item 22 below.	No

22. Indicate the type(s) of other insurance:

TRICARE Other *Name of other insurance:* _____ *Policy Number:* _____

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	29. Relationship code
			M F	

30. Address *(if different from enrollee)*	31. If this family member is covered by Medicare, check all that apply.	32. Medicare Claim Number
	A B D	
	33. Is this family member covered by insurance other than Medicare?	
	Yes, indicate in item 34 below.	No

34. Indicate the type(s) of other insurance:

TRICARE Other *Name of other insurance:* _____ *Policy Number:* _____

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	41. Relationship code
			M F	

42. Address *(if different from enrollee)*	43. If this family member is covered by Medicare, check all that apply.	44. Medicare Claim Number
	A B D	
	45. Is this family member covered by insurance other than Medicare?	
	Yes, indicate in item 46 below.	No

46. Indicate the type(s) of other insurance

TRICARE Other *Name of other insurance:* *Policy Number:*

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.*

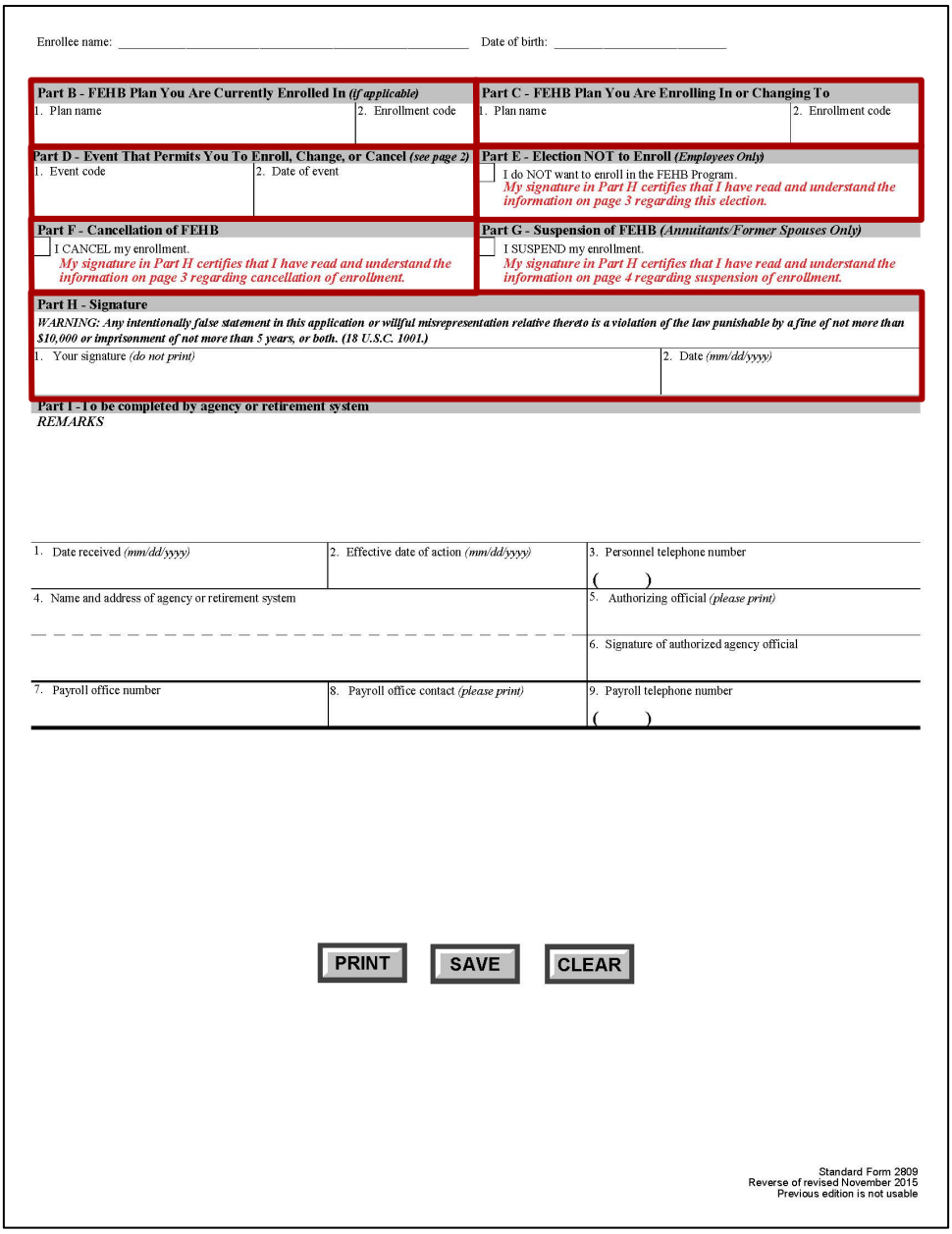
47. Email address *(if applicable, enter email address of your spouse or adult child)*	48. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

(Continued on the reverse)

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

U.S. Office of Personnel Management

Standard Form 2809
Revised November 2015
Previous edition is not usable.



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 2)*

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/Former Spouses Only)*

☐ I SUSPEND my enrollment.
My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.

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

REMARKS

1. Date received *(mm/dd/yyyy)*	2. Effective date of action *(mm/dd/yyyy)*	3. Personnel telephone number ( )
4. Name and address of agency or retirement system		5. Authorizing official *(please print)*
		6. Signature of authorized agency official
7. Payroll office number	8. Payroll office contact *(please print)*	9. Payroll telephone number ( )

PRINT SAVE CLEAR

Standard Form 2809
Reverse of revised November 2015
Previous edition is not usable

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. Live agents are available 7:00 a.m. to 10:00 p.m. Eastern Standard Time (EST) Monday through Friday, excluding Federal

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.