UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT OPERATIONS
WASHINGTON, DC 20415-3532

For CSRS and FERS Annuitants, Survivor Annuitants, and Former Spouse Annuitants

Date
Claim number **CS**

Health Benefits Cancellation/Suspension Confirmation

You asked us to cancel or suspend your enrollment in the Federal Employees Health Benefits Program (FEHBP). Please read the front and back of this form and check only the ONE block that applies to you. Please note that the Affordable Care Act (ACA) requires that individuals maintain minimum essential coverage (MEC). For more information, please visit the IRS website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision. Because many annuitants who cancel their FEHBP enrollments will not be eligible to reenroll, we want to be sure you are fully informed about the effect of any action you take. We will not process your request until you sign, date, and return this form indicating that you understand how your request will affect your future FEHBP enrollment eligibility. ***Any Questions? Call OPM at 1-888-767-6738.***

A. ☐ **I am cancelling my FEHBP enrollment to be covered under a family member's FEHBP enrollment.**
If you are cancelling your FEHBP enrollment because you will be covered under your spouse's FEHBP enrollment and your spouse is a Federal employee, please include with this form a copy of your spouse's SF 2809, *Health Benefits Registration Form*, showing the change to a family enrollment. If your spouse is an annuitant, please give us your spouse's name and annuity claim number.

Spouse's name *(Last, first, middle)*	Spouse's claim number

If you cancel FEHBP coverage for this reason, we will coordinate the effective date with the effective date of your new coverage under your spouse's enrollment.

Reenrollment eligibility: As long as you are continuously covered as a family member on your spouse's FEHBP enrollment, you will be eligible to resume your own enrollment if your coverage under your spouse's enrollment ends for any reason.

B. ☐ **I am cancelling my FEHBP coverage for reasons other than the situation described in part A.**
We will cancel your enrollment effective the end of the month in which we receive this signed and dated form. Any health benefits premiums you pay for a period after the cancellation effective date will be refunded in one of your future monthly annuity payments.

Reenrollment eligibility: If you check this block to cancel your FEHB enrollment, you will not be eligible to reenroll in the FEHBP. Additionally, if you cancel your FEHBP enrollment, you and any family members covered by your enrollment will not be entitled to the free 31-day extension of coverage to convert to an individual health benefits contract or to enroll for Temporary Continuation of Coverage.

I certify that I have read and understand the information on cancelling FEHBP coverage. I understand that if I checked block B, ***I will never again be eligible*** to enroll in the Federal Employees Health Benefits Program.		
Signature	Daytime Telephone No. *(including area code)*	Date

SUSPENSION INFORMATION IS SHOWN ON THE REVERSE

C. ☐ **I am suspending my Federal Employees Health Benefits Program (FEHBP) enrollment because I am enrolled in a Medicare Advantage health plan.** *Please note: Medicare Parts A and B are not the same as a Medicare Advantage health plan. You CANNOT suspend your FEHBP enrollment if you are covered by Medicare Parts A and/or B only.* ***Any Questions: Call Medicare at 1-800-633-4227.***

These Medicare Advantage health plans are Health Maintenance Organizations or Fee-For-Service plans approved by the Centers for Medicare and Medicaid Services (CMS). If you are enrolled in a Medicare supplemental plan and are not sure if it qualifies as a Medicare Advantage health plan, call Medicare at the number shown above. To suspend your FEHBP coverage for this reason, you must give us documentation that shows the effective date of your Medicare Advantage health plan coverage. If we receive this form within 31 days before to 31 days after the effective date of your Medicare Advantage health plan enrollment, we will suspend your FEHBP coverage at the close of business the day before your Medicare Advantage health plan enrollment begins. Otherwise, we will suspend your FEHBP coverage at the end of the month in which we receive your documentation.

D. ☐ **I am suspending my FEHBP enrollment to use TRICARE, TRICARE for Life (enrollees over age 65 with Medicare Parts A and B), Peace Corps, or CHAMPVA. Please suspend my FEHBP enrollment effective _____. (Carefully consider the effective date of your suspension. Once we process your request, we are not able to change the effective date.)**

To suspend your FEHBP coverage for this reason, you must give us evidence of your eligibility for TRICARE, TRICARE for Life, Peace Corps, or CHAMPVA. Please send us a copy of your Uniformed Services Identification (I.D.) card and if over age 65, you must also send us a copy of your Medicare card showing enrollment in both Medicare Parts A and B (required for TRICARE for Life). To document your eligibility for CHAMPVA, please send us a copy of your CHAMPVA Authorization Card (A-card). Please tell us the date you want to suspend your FEHBP to use TRICARE, TRICARE for Life, Peace Corps, or CHAMPVA. **Special note:** If we receive this signed form and the eligibility documentation within 31 days before to 31 days after the date you designate above, we will suspend your FEHBP coverage on that date. Otherwise, we will suspend your FEHBP coverage at the end of the month in which we receive your documentation.

E. ☐ **I am suspending my FEHBP enrollment because I am eligible for coverage under Medicaid or a similar state-sponsored program of medical assistance for the needy.**

To suspend your FEHBP coverage for this reason, you must give us evidence of your eligibility for Medicaid or a similar state-sponsored program of medical assistance for the needy. You may send us a copy of an enrollment card or a letter of eligibility which shows the effective date of your Medicaid or similar state-sponsored program coverage. If we receive this signed form and documentation within 31 days before to 31 days after the effective date of your Medicaid or similar state-sponsored enrollment, we will suspend your FEHBP coverage at the close of business the day before your Medicaid or state-sponsored program coverage begins. Otherwise, we will suspend your FEHBP coverage at the end of the month in which we receive your documentation.

The following information applies to blocks C, D and E.

Reenrollment: You may voluntarily reenroll in the FEHBP during an annual open season. We will send you an open season package each year with instructions on how to reenroll. If you don't want to reenroll, disregard your open season material.

If you involuntarily lose your coverage under one of the programs mentioned above, you can reenroll in the FEHBP effective the day after your coverage ends. You must provide evidence of your involuntary loss of coverage. Your request to reenroll must be received at the Office of Personnel Management (OPM) within the period beginning 31 days before and ending 60 days after your coverage ends. Otherwise, you must wait until open season to reenroll.

I certify that I have read and understand the information on suspending FEHBP coverage. I have checked the block relating to my suspension, and I have enclosed the appropriate documentation.		
Signature	Daytime Telephone No. *(including area code)*	Date

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