

NOTIFICATION TO ENROLLEE OF ADULT CHILD'S REQUEST TO BE REMOVED

*Dear (enrollee's name):*

*Your adult child (insert family member(s) name) has requested to be removed from your Federal Employees Health Benefits (FEHB) Program enrollment.*

*(Name of adult child)'s FEHB coverage ends effective XXXX, XX, 20XX*

*(Name of adult child) is not eligible for the 31-day temporary extension of coverage, conversion to an individual policy, or temporary continuation of coverage (TCC).*

*A removed child may only regain coverage under your Self Plus One or Self and Family enrollment if requested by you during the annual Federal Benefits Open Season or within 60 days of the child losing other health insurance coverage. You must provide written consent to reinstate coverage from the adult child and demonstrate eligibility of the adult child as a family member.*

*This is not an opportunity to change plans, plan options or enrollment type.*

*Regards,*

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NOTIFICATION TO ADULT CHILD OR SPOUSE OF REMOVAL FROM FEHB

*Dear (family member's name):*

*(Enrollee's Name) has requested that you be removed from (his/her) Federal Employees Health Benefits (FEHB) Program Self and Family (or Self Plus One) enrollment.*

*Your coverage ends effective XXXX, XX, 20XX*

*You are not eligible for the 31-day temporary extension of coverage, conversion to an individual policy, or temporary continuation of coverage (TCC).*

*You can only regain coverage under the applicable Self Plus One or Self and Family enrollment if requested by the enrollee during the annual Federal Benefits Open Season or within 60 days of you losing other health insurance coverage.*

*Regards,*