ATTACHMENT 1: TRIBAL EMPLOYER REQUEST FOR VERIFICATION OF FAMILY MEMBER ELIGIBILITY

FOR EMPLOYING OFFICE USE

[INSERT DATE]

[INSERT EMPLOYEE NAME AND ADDRESS]

Dear [EMPLOYEE]:

We are conducting an eligibility review of certain family members covered under your Federal Employees Health Benefits (FEHB) enrollment. 83 FR 3059 (e) allows for an employing office to request that an employee verify the eligibility of any or all family members covered under the employee's FEHB enrollment at any time.

Our records show that the following family member(s) are being provided coverage under your [(Self Plus One) (Self and Family)] enrollment.

1. [INSERT NAME OF COVERED FAMILY MEMBER]
2. [INSERT NAME OF COVERED FAMILY MEMBER]

Eligible family members are limited to:

- Your current spouse
- Your children under age 26, including:
  - Adopted children
  - Stepchildren
  - Foster children under certain circumstances
- An adult child incapable of self-support because of a mental or physical disability that existed before age 26

Please see the U.S. Office of Personnel Management website (www.opm.gov/healthcare-insurance/healthcare/reference-materials/reference/eligibility-for-health-benefits/) for more information on eligible family members.

You must comply with this request and submit documentation of each family member's eligibility within 60 calendar days from the date of this notice. Please see the attached *FEHB Family Member Eligibility Documents* for information on appropriate documentation. If you do not submit appropriate documentation that confirms eligibility of your family member(s) to be covered under your FEHB enrollment, the person(s) will be removed from coverage under your FEHB enrollment 60 calendar days from the date of this notice.

Send the documentation to:

[INSERT specific instructions to receive documents requested]

Any intentional false statement or willful misrepresentation, such as including an ineligible family member on an FEHB health plan, is a violation of the law (18 U.S.C. 1001.).

If you have questions about this request, you may contact us at:

[INSERT CONTACT INFORMATION]

[SIGNATURE]

Attachment FEHB Family Member Eligibility Acceptable Documents

cc: [FEHB Carrier]