Declaration for Federal Employment

Form Approved
OMB No. 3206-0182

Instructions

The information collected on this form is used to determine your acceptability for Federal and Federal contract employment and
your enrollment status in the Government's Life Insurance program. You may be asked to complete this form at any time during the hiring process. Follow instructions that the agency provides. If you are selected, before you are appointed you will be asked to
update your responses on this form and on other materials submitted during the application process and then to recertify that your
answers are true.

All your answers must be truthful and complete. A false statement on any part of this declaration or attached forms or sheets may be grounds for not hiring you, or for firing you after you begin work. Also, you may be punished by a fine or

Privacy Act Statement

The Office of Personnel Management is authorized to request this information under sections 1302, 3301, 3304, 3328, and 8716 of title 5, U. S. Code. Section 1104 of title 5 allows the Office of Personnel Management to delegate personnel management functions to other Federal agencies. If necessary, and usually in conjunction with another form or forms, this form may be used in conducting an investigation to determine your suitability or your ability to hold a security clearance, and it may be disclosed to authorized officials making similar, subsequent determinations.

Your Social Security Number (SSN) is needed to keep our records accurate, because other people may have the same name and birth date. Public Law 104-134 (April 26, 1996) asks Federal agencies to use this number to help identify individuals in agency records. Giving us your SSN or any other information is voluntary. However, if you do not give us your SSN or any other information requested, we cannot process your application. Incomplete addresses and ZIP Codes may also slow processing.

ROUTINE USES: Any disclosure of this record or information in this record is in accordance with routine uses found in System Notice OPM/GOVT-1, General Personnel Records. This system allows disclosure of information to: training facilities; organizations deciding claims for retirement, insurance, unemployment, or health benefits; officials in litigation or administrative proceedings where the Government is a party; law enforcement agencies concerning a violation of law or regulation; Federal agencies for statistical reports and studies; officials of labor organizations recognized by law in connection with representation of employees; Federal agencies or other sources requesting information for Federal agencies in connection with hiring or retaining, security clearance, security or suitability investigations, classifying jobs, contracting, or issuing licenses, grants, or other benefits; public and private organizations, including news media, which grant or publicize employee recognitions and awards; the Merit Systems Protection Board, the Office of Special Counsel, the Equal Employment Opportunity Commission, the Federal Labor Relations Authority, the National Archives and Records Administration, and Congressional offices in connection with their official functions; prospective non-Federal employers concerning tenure of employment, civil service status, length of service, and the date and nature of action for separation as shown on the SF 50 (or authorized exception) of a specifically identified individual; requesting organizations or

Public Burden Statement

Public burden reporting for this collection of information is estimated to vary from 5 to 30 minutes with an average of 15
minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and
completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the

Declaration for Federal Employment

Form Approved
OMB No. 3206-0182

GENERAL INFORMATION

1. **FULL NAME** *(First, middle, last)*

2. **SOCIAL SECURITY NUMBER**

3. **PLACE OF BIRTH** *(Include city and state or country)*

4. **DATE OF BIRTH** *(MM/DD/YYYY)*

5. **OTHER NAMES EVER USED** *(For example, maiden name, nickname, etc)*

6. **PHONE NUMBERS** *(Include area codes)*

Day

Night

Selective Service Registration

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must register with the Selective Service System, unless you meet certain exemptions.

7a. Are you a male born after December 31, 1959? ☐ YES ☐ NO *If "NO" skip 7b and 7c. If "YES" go to 7b.*

7b. Have you registered with the Selective Service System? ☐ YES ☐ NO *If "NO" go to 7c.*

7c. If "NO," describe your reason(s) in item #16.

Military Service

8. Have you ever served in the United States military? ☐ YES *Provide information below* ☐ NO

If you answered "YES," list the branch, dates, and type of discharge for all active duty.

If your only active duty was training in the Reserves or National Guard, answer "NO."

Branch	From MM/DD/YYYY	To MM/DD/YYYY	Type of Discharge

Background Information

For all questions, provide all additional requested information under item 16 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 9,10, and 11, your answers should include convictions resulting from a plea of *nolo contendere* (no contest), but omit (1) traffic fines of $300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law, and (5) any conviction for which the record was expunged under Federal or state law.

9. During the last 10 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* YES ☐ NO ☐

10. Have you been convicted by a military court-martial in the past 10 years? *(If no military service, answer "NO.") If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.* YES ☐ NO ☐

11. Are you now under charges for any violation of law? *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* YES ☐ NO ☐

12. During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? *If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.* YES ☐ NO ☐

13. Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) *If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.* YES ☐ NO ☐

Declaration for Federal Employment

Form Approved:
OMB No. 3206-0182

Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) *If "YES," use item 16 to provide the relative's name, relationship, and the department, agency, or branch of the Armed Forces for which your relative works.*

YES ☐ NO ☐

15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service?

YES ☐ NO ☐

Continuation Space / Agency Optional Questions

16. Provide details requested in items 7 through 15 and 18c in the space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed *(these questions are specific to your position and your agency is authorized to ask them).*

Certifications / Additional Questions

APPLICANT: If you are applying for a position and have not yet been selected, carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, read item 17, and complete 17a.

APPOINTEE: If you are being appointed, carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, read item 17, complete 17b, read 18, and answer 18a, 18b, and 18c as appropriate.

17. **I certify** that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith. **I understand that a false or fraudulent answer to any question or item on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand** that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. **I consent** to the release of information about my ability and fitness for Federal employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists, and other authorized employees or representatives of the Federal Government. **I understand** that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date.

17a. Applicant's Signature: _____ Date _____
(Sign in ink)

17b. Appointee's Signature: _____ Date _____
(Sign in ink)

Appointing Officer:
Enter Date of Appointment or Conversion
MM / DD / YYYY

18. **Appointee (Only respond if you have been employed by the Federal Government before):** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

18a. When did you leave your last Federal job? DATE: MM / DD / YYYY

18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance? YES ☐ NO ☐ Do Not Know ☐

18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled. YES ☐ NO ☐ Do Not Know ☐

Statement of Prior Federal Service

(PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THIS

Privacy Act Statement

Section 6303 of 5 U.S.C., "Annual Leave Accrual," authorizes collection of information to determine and record service that may be creditable for accrual of annual leave. Part 351.503, 5 C.F.R., "Length of Service," authorizes collection of data to determine and record service that may be creditable for reduction-in-force retention purposes.

Information about prior Federal civilian and military service is collected and maintained in your Official Personnel Folder (OPF). The information you furnish may be disclosed to other Federal agencies or Congressional or Judicial Offices in order to verify it or in connection with your application for a job, license, grant, or other benefit. It may also be disclosed to a national, state, or local law enforcement agency where there is indication of a violation or potential violation of civil or criminal law or regulation, or to another Federal agency or court when the Government is party to a suit.

Furnishing this information is voluntary; however, failure to do so may result in your not receiving credit for prior Federal service.

I. What is Needed to Verify Prior Service

In order for your employing agency to credit your prior Federal service for benefits, such as leave accrual and reduction-in-force retention, the dates of your active uniformed service and the type(s) of appointment(s) and dates of civilian service must be verified. Dates of active uniformed service are verified from the records issued by the branch of service in which you served. Dates and types of appointments to civilian positions are usually verified from Notifications of Personnel Action (Standard Form 50 or CSC- or OPM-approved exceptions thereto), and payroll records (including records of deductions made under the Civil Service Retirement System - Standard Form 2806, or the Federal Employees Retirement System - Standard Form 3100). The information on the application or resume you submitted for the appointment you are receiving, along with the information on page 2 of this form, will be used by your agency to identify the Federal employers and periods of employment for which records must be obtained to verify the prior service.

When Notification of Personnel Action or payroll records cannot be located to verify a period of service, and the service was covered by Social Security, a detailed statement of earnings information (showing periods of employment and the name of the employer) from the Social Security Administration will be accepted as proof of service.

If no personnel, payroll, or Social Security records can be located, then your agency can accept secondary evidence of civilian employment, as explained below.

II. Use of Secondary Evidence to Verify Federal Service

Secondary evidence may be considered as proof of Federal civilian service only when official Government records are lost, destroyed, or incomplete. Necessarily, the **burden of proof is on the person claiming service** that is not supported by official records in the custody of the U.S. Government. If you decide to claim credit for a period of service by submitting secondary evidence, it is important that you **submit all documents in your possession** that tend to prove you performed the service claimed, and that the service, if performed, was creditable for leave accrual and reduction-in-force purposes. **No credit** can be allowed for any service that is **not substantiated** by valid and conclusive secondary evidence. The following is applicable only if you are providing secondary evidence.

A. Documentary Evidence: Submit as many as possible of the documents listed in item 1 below. If your agency finds that these documents are insufficient to determine creditability, the documents listed in items 2 and 3 may be considered, but less weight will be given to such evidence.

1. Copies of official documents or letters about the service. These may be notices on appointment/separation; notices of changes in position/salary, organization, or head-quarters; travel orders; payroll cards; ID's, etc.

2. Private records such as a diary, correspondence, copies of income tax returns, employment applications, credit applications, etc., that mention the Federal employer and the claimed service. Private records must have been made during or shortly after period of service.

3. Any other documentary evidence tending to prove the service was actually performed and the starting and ending dates of the service.

B. Affidavit Evidence: If you are not able to supply copies of official documents (as described in item 1 above) that are sufficient for your agency to make a determination of creditability, you must submit affidavits from yourself and at least two other persons (preferably your supervisors) who know the facts. If you can obtain no documentary evidence (items 1, 2, and 3, above) to support your claim, you may submit these affidavits only; **however,** your claim is more likely to be rejected without supporting documents. The required affidavits are from:

– The employee, stating as many of the details on the affidavit as can accurately be remembered.

– At least two persons knowing the facts. Each person should show that he or she is in a position to know the facts sworn to, and give his or her age and mailing address.

Affidavits must be sworn to or affirmed before a notary public or other officer who is authorized by law to administer oaths.

C. Warning: Any submission may be investigated. Intentional false statements, willful concealments, or using documents you know are false, fictitious, or fraudulent is punishable by fine/ imprisonment (18 U.S.C. 1001).

STATEMENT OF PRIOR FEDERAL SERVICE
To be Completed by Employee

1. Name (Last, First, Middle Initial)	2. Social Security Number	3. Date of Birth (Month, Day, Year)

4. Does the application or resume that you submitted, for the position to which you are being appointed, list all of your Federal government civilian and uniformed service, including beginning and ending dates, as well as the type of appointment and work schedule for civilian service?

☐ Yes - If "Yes", check this block and skip to Item 8. ☐ No - If "No", check this block and complete Items 5 - 9.

5. List below your prior civilian service. Include service with the DC Government on appointments made before October 1, 1987.

NAME AND LOCATION OF AGENCY	FROM			TO			TYPE OF APPOINTMENT AND WORK SCHEDULE (Full-Time, Part-Time, or Intermittent)
	Year	Month	Day	Year	Month	Day	

6. During periods of employment shown in Item 5, did you have a total of more than 6 months' absence without pay during any one calendar year?

☐ Yes - If "Yes", list the following information. ☐ No - If "No", go to Item 7.

TYPE OF ABSENCE, IF KNOWN (LWOP, Furlough, Suspension, AWOL, or Placement in Nonpay Status)	FROM			TO			TOTAL		
	Year	Month	Day	Year	Month	Day	YEARS	MONTHS	DAYS
			☐						

7. List all uniformed service below. List active service in any branch of the Armed Forces of the United States, including active duty as a reservist, and active service in the commissioned corps of the Public Health Service or the National Oceanic and Atmospheric Administration.

BRANCH OF SERVICE	FROM			TO			DISCHARGE (Honorable or Dishonorable)
	Year	Month	Day	Year	Month	Day	

8. Do you claim any type of veterans' preference which has not been verified?

☐ No ☐ Yes - Check one of the statements, if it applies to you. I claim preference as the:

☐ Spouse of a disabled veteran ☐ Mother of a deceased or disabled veteran ☐ Unmarried widow/widower of a veteran

9. CERTIFICATION: The prior Federal civilian and uniformed service listed on my application/resume and listed above constitutes my entire record of Federal employment. I have no other Federal service for which I want to claim credit.

Signature	Date

Department of Homeland Security
U.S. Citizenship and Immigration Services

OMB No. 1615-0047; Expires 03/31/07

Employment Eligibility Verification

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1- Employee.

All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

Section 2 - Employer.

For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1)** document title; **2)** issuing authority; **3)** document number, **4)** expiration date, if any; and **5)** the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

Section 3 - Updating and Reverification.

Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:
  - examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C),
  - record the document title, document number and expiration date (if any) in Block C, and
  - complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, 5 minutes; **2)** completing the form, 5 minutes; and **3)** assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachuetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

EMPLOYERS MUST RETAIN COMPLETED FORM I-9
PLEASE DO NOT MAIL COMPLETED FORM I-9 TO ICE OR USCIS

Department of Homeland Security
U.S. Citizenship and Immigration Services

OMB No. 1615-0047; Expires 03/31/07

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*

City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien #) A _____
- ☐ An alien authorized to work until ___ ___ ___
  (Alien # or Admission #) _____

Employee's Signature	Date *(month/day/year)*

Preparer and/or Translator Certification.

(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification.

To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date *(if any)*: ___/___/___		___/___/___		___/___/___
Document #: _____				
Expiration Date *(if any)*: ___/___/___				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* ___/___/___ **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title

Business or Organization Name	Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name *(if applicable)*	B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title:_____ Document #: _____ Expiration Date (if any): ___/___/___

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

LISTS OF ACCEPTABLE DOCUMENTS

LIST A

Documents that Establish Both Identity and Employment Eligibility

1. U.S. Passport (unexpired or expired)

2. Certificate of U.S. Citizenship *(Form N-560 or N-561)*

3. Certificate of Naturalization *(Form N-550 or N-570)*

4. Unexpired foreign passport, with *I-551 stamp or* attached *Form I-94* indicating unexpired employment authorization

5. Permanent Resident Card or Alien Registration Receipt Card with photograph *(Form I-151 or I-551)*

6. Unexpired Temporary Resident Card *(Form I-688)*

7. Unexpired Employment Authorization Card *(Form I-688A)*

8. Unexpired Reentry Permit *(Form I-327)*

9. Unexpired Refugee Travel Document *(Form I-571)*

10. Unexpired Employment Authorization Document issued by DHS that contains a photograph *(Form I-688B)*

OR

LIST B

Documents that Establish Identity

1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address

2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address

3. School ID card with a photograph

4. Voter's registration card

5. U.S. Military card or draft record

6. Military dependent's ID card

7. U.S. Coast Guard Merchant Mariner Card

8. Native American tribal document

9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card

11. Clinic, doctor or hospital record

12. Day-care or nursery school record

AND

LIST C

Documents that Establish Employment Eligibility

1. U.S. social security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*

2. Certification of Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*

3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal

4. Native American tribal document

5. U.S. Citizen ID Card *(Form I-197)*

6. ID Card for use of Resident Citizen in the United States *(Form I-179)*

7. Unexpired employment authorization document issued by DHS *(other than those listed under List A)*

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

U.S. Office of Personnel Management Guide to Personnel Data Standards	**ETHNICITY AND RACE IDENTIFICATION** (Please read the Privacy Act Statement and instructions before completing form.)	
Name (Last, First, Middle Initial)	Social Security Number	Birthdate (Month and Year)
Agency Use Only		

Privacy Act Statement Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation. This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U. S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies. Social Security Number (SSN) is requested under the authority of Executive Order 9397, which requires SSN be used for the purpose of uniform, orderly administration of personnel records. Providing this information is voluntary and failure to do so will have no effect on your employment status. If SSN is not provided, however, other agency sources may be used to obtain it.

Specific Instructions: The two questions below are designed to identify your ethnicity and race. **Regardless of your answer to question 1, go to question 2**.

Question 1. Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) ☐ Yes ☐ No

Question 2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.

RACIAL CATEGORY (Check as many as apply)	DEFINITION OF CATEGORY
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. A person having origins in any of the black racial groups of Africa. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Standard Form 181
Revised August 2005
Previous editions not usable

42 U.S.C. Section 2000e-16

NSN 7540-01-099-3446

Name: _____
(Print Last, First, Middle Initial)

PRE-APPOINTMENT CERTIFICATION STATEMENT
FOR
SELECTIVE SERVICE REGISTRATION

Important Notice	If you are a male born after December 31, 1959, and you want to be employed by the Federal Government, you must (subject to certain exemptions) be registered with the Selective Service System.
Privacy Act Statement	We need information on your registration with the Selective Service System to see whether you are affected by the laws we must follow in deciding who may be employed by the Federal Government.
Criminal Penalty Statement	A false statement by you may be grounds for not hiring you, or firing you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).
Review	If your employing agency has informed you that you cannot be appointed to a position in an executive agency because of your failure to register, and you wish to establish that your non-compliance with the law was neither knowing nor willful, you may write to:

U.S. Office of Personnel Management
NACI Center
IOD-SAB
Boyers, Pennsylvania 16018

CERTIFICATION OF REGISTRATION STATUS

Check one:

- ☐ I certify I am registered with the Selective Service System.
- ☐ I certify I have been determined by the Selective Service System to be exempt from the registration provisions of Selective Service Law.
- ☐ I certify I have not registered with the Selective Service.
- ☐ I certify I have not reached my 18th birthday and understand I am required by law to register at that time.

_____ _____
Legal signature (please use ink) Date signed (please use ink)

Form W-4 (2006)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2006 expires February 16, 2007. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $850 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2006. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A**
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.	**B**
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C**
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D**
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E**
F	Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See **Pub. 503,** Child and Dependent Care Expenses, for details.)	**F**
G	**Child Tax Credit** (including additional child tax credit): • If your total income will be less than $55,000 ($82,000 if married), enter "2" for each eligible child. • If your total income will be between $55,000 and $84,000 ($82,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have four or more eligible children.	**G**
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H**

For accuracy, complete all worksheets that apply.

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $35,000 ($25,000 if married) see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2006

1 Type or print your first name and middle initial.	Last name	**2** Your social security number
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	**4** If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card. ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**
6	Additional amount, if any, you want withheld from each paycheck	**6** $
7	I claim exemption from withholding for 2006, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	**7**

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (Form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2006 tax return.

1	Enter an estimate of your 2006 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2006, you may have to reduce your itemized deductions if your income is over $150,500 ($75,250 if married filing separately). See *Worksheet 3* in Pub. 919 for details.)	1	$
2	Enter: { $10,300 if married filing jointly or qualifying widow(er); $ 7,550 if head of household; $ 5,150 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If line 2 is greater than line 1, enter "-0-"	3	$
4	Enter an estimate of your 2006 adjustments to income, including alimony, deductible IRA contributions, and student loan interest	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 7* in Pub. 919)	5	$
6	Enter an estimate of your 2006 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. Enter the result, but not less than "-0-"	7	$
8	**Divide** the amount on line 7 by $3,300 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earner/Two-Job Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earner/Two-Job Worksheet (See *Two earners/two jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is *less than* line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2006. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2005. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1: Two-Earner/Two-Job Worksheet

Married Filing Jointly						All Others	
If wages from **HIGHEST** paying job are—	AND, wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **HIGHEST** paying job are—	AND, wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $42,000	$0 - $4,500	0	$42,001 and over	32,001 - 38,000	6	$0 - $6,000	0
	4,501 - 9,000	1		38,001 - 46,000	7	6,001 - 12,000	1
	9,001 - 18,000	2		46,001 - 55,000	8	12,001 - 19,000	2
	18,001 and over	3		55,001 - 60,000	9	19,001 - 26,000	3
$42,001 and over	$0 - $4,500	0		60,001 - 65,000	10	26,001 - 35,000	4
	4,501 - 9,000	1		65,001 - 75,000	11	35,001 - 50,000	5
	9,001 - 18,000	2		75,001 - 95,000	12	50,001 - 65,000	6
	18,001 - 22,000	3		95,001 - 105,000	13	65,001 - 80,000	7
	22,001 - 26,000	4		105,001 - 120,000	14	80,001 - 90,000	8
	26,001 - 32,000	5		120,001 and over	15	90,001 - 120,000	9
						120,001 and over	10

Table 2: Two-Earner/Two-Job Worksheet

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $60,000	$500	$0 - $30,000	$500
60,001 - 115,000	830	30,001 - 75,000	830
115,001 - 165,000	920	75,001 - 145,000	920
165,001 - 290,000	1,090	145,001 - 330,000	1,090
290,001 and over	1,160	330,001 and over	1,160

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Government of the District of Columbia

D-4 Employee Withholding Allowance Certificate

Year

Your first name | M.I. | Last name

Home address (number and street) | Apartment number

Social security number

City | State | Zip code

1 Tax filing status *Fill in only one:* ○ Single ○ Married filing jointly ○ Married filing separately ○ Head of household ○ Married filing separately on same return

2 Total number of withholding allowances from worksheet below

3 Additional amount, if any, you want withheld from each paycheck $

4 If you are claiming exemption from withholding, read below and write "EXEMPT" in this box.

I am exempt because: last year I did not owe any DC income tax and had a right to a full refund of all DC income tax withheld from me; and this year I do not expect to owe any DC income tax and expect a full refund of all DC income tax withheld from me; and I qualify for exempt status on federal Form W-4.

If claiming exemption, are you a full-time student? ○ Yes ○ No

Signature Under penalties of law, I declare that I have examined this certificate and to the best of my knowledge it is correct.

Employee's signature | Date

Employer Keep this certificate with your records. If 10 or more exemptions are claimed or if you suspect this certificate contains false information please send a copy to: Office of Tax and Revenue, 941 North Capitol St., NE, Washington, DC 20002-4259 Attn: Compliance Administration

✂ **Detach and give top portion to your employer. Keep bottom portion for your records.**

Government of the District of Columbia

D-4 Employee Withholding Allowance Worksheet

YEAR

Section A Number of withholding allowances

a	Enter 1 for yourself and	a
b	Enter 1 if you are filing as a head of household and	b
c	Enter 1 if you are 65 or over and	c
d	Enter 1 if you are blind	d
e	Enter number of dependents	e
f	Enter 1 for your spouse if filing jointly	f
g	Enter 1 if married filing jointly and your spouse is 65 or over and	g
h	Enter 1 if married filing jointly and your spouse is blind	h
i	Number of allowances *Add Lines a through h and enter on Line 2. If you would like to claim additional allowances, complete section B below.*	i

Section B Additional withholding allowances

j	Enter estimate of your itemized deductions	j	
k	Enter $1,250 if married filing separately; all others enter $2,500	k	
l	Subtract k from j	l	
m	Multiply $1,500 by number of allowances on Line i	m	
n	Divide l by m. Round to the nearest whole number.		n
o	Add Lines n and i and enter on Line 2 above.		o

✂ **Detach and give top portion to your employer. Keep bottom portion for your records.**

Who must file a Form D-4?
Every new employee who resides in DC and who is required to have taxes withheld, must fill out Form D-4 and file it with his/her employer. If you are not liable for DC taxes because you are a nonresident you must file Form D-4A (Certificate of Nonresidence in the District of Columbia) with your employer.

When should you file?
File Form D-4 whenever you start new employment. Once filed with your employer, it will remain in effect until you file an amended certificate. You may file a new withholding allowance certificate any time if the number of withholding allowances you are entitled to increases. You must file a new certificate within 10 days if the number of withholding allowances you claimed decreases.

How many withholding allowances should you claim?
Use the worksheet on the front of this form to figure the number of withholding allowances you should claim. If you want less money withheld from your paycheck, you may claim additional allowances by completing Section B of the worksheet, Lines j through o. However, if you claim too many allowances, you may owe taxes at the end of the year.

Should I deduct an additional amount from my paycheck?
In some instances, even if you claim zero withholding allowances, you may not have enough tax withheld. You may, upon agreement with your employer, have more tax withheld by entering on Line 3, a dollar amount of your choosing.

What to file
After completing Form D-4, detach the top portion and file it with your employer. Keep the bottom portion for your records.

FORM

MW 507

Employee's Maryland Withholding Exemption Certificate

Print your full name	Your social security number
Address (including ZIP code)	County of residence (or Baltimore City)

1. Total number of exemptions you are claiming from worksheet below 1. _____

2. Additional withholding per pay period under agreement with employer 2. _____

3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions below and check boxes that apply.

   ☐ a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld.
   AND

   ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirement).

   If both **a** and **b** apply, enter year applicable _____(year effective) Enter "EXEMPT" here 3. _____

4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.

   ☐ District of Columbia ☐ Pennsylvania ☐ Virginia ☐ West Virginia

   I further certify that I do not maintain a place of abode in Maryland as described in the instructions on page 2.

   Enter "EXEMPT" here 4. _____

Under the penalty of perjury, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3 or line 4, whichever applies.

Employee's signature_____ Date_____

Employer's name and address (including zip code) (For employer use only)	Federal employer identification number

Worksheet and instructions

Line 1

a. Number of personal exemptions (total exemptions on lines A, C and D of the federal W-4 or W-4A worksheet). **a.** _____

b. Number of additional exemptions for dependents over 65 years of age. **b.** _____

c. Number of additional exemption for certain items, including estimated itemized deductions, alimony payments, allowable childcare expenses, qualified retirement contributions, business losses and employee business expenses for the year. **c.** _____

d. Number of additional exemptions for taxpayer and/or spouse at least 65 years of age and/or blind. **d.** _____

e. Total - add lines a through d and enter here and on line 1 (Form MW 507). **e.** _____

EXEMPTIONS FOR DEPENDENTS To qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding tax year.

ADDITIONAL EXEMPTIONS FOR DEPENDENTS OVER 65 YEARS OF AGE An additional exemption is allowed for dependents who are 65 years of age or older.

ADDITIONAL EXEMPTIONS You may claim additional exemptions for certain items, including estimated itemized deductions, alimony payments, allowable child care expenses, qualified retirement contributions, business losses and employee business expenses for the year. One additional withholding exemption is permitted for each $2,400 of estimated itemized deductions or adjustments to income that exceed the standard deduction allowance.

NOTE: Standard deduction allowance is 15% of Maryland adjusted gross income with a minimum of $1,500 and a maximum of $2,000 for each taxpayer.

ADDITIONAL EXEMPTIONS FOR TAXPAYER AND/OR SPOUSE An additional $1,000 may be claimed if the taxpayer and/or spouse is at least 65 years of age and/or blind on the last day of the tax year.

Line 2

ADDITIONAL WITHHOLDING PER PAY PERIOD UNDER AGREEMENT WITH EMPLOYER If you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on line 2.

Line 3

WHO MAY CLAIM EXEMPTION FROM WITHHOLDING OF INCOME TAX You may be entitled to claim an exemption from the withholding of Maryland income tax if:

a. last year you did not owe any Maryland income tax and had a right to a full refund of any tax withheld; and

b. this year you do not expect to owe any Maryland income tax and expect to have a right to a full refund of all income tax withheld. If you are eligible to claim this exemption, your employer will not withhold Maryland income tax from your wages.

STUDENTS AND SEASONAL EMPLOYEES whose annual income will be below the minimum filing requirements should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

Line 4

CERTIFICATION OF NONRESIDENCE IN THE STATE OF MARYLAND This line is to be completed by residents of the District of Columbia, Pennsylvania, Virginia or West Virginia who are employed in Maryland and who do not maintain a place of abode in Maryland for more than 183 days.

Line 4 is *not* to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia, Pennsylvania or Virginia (Virginia residents see note below) and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law.

If you are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

NOTE: If you are domiciled in Virginia, you must commute daily to Maryland to be exempt from withholding. If you reside in Maryland for at least one day but less than 183 days, you will be subject to Maryland tax on your income from Maryland sources as a nonresident of Maryland.

GENERAL INSTRUCTIONS

FEDERAL PRIVACY ACT INFORMATION Social security numbers must be included. The mandatory disclosure of your social security number is authorized by the provisions set forth in the Tax-General Article of the Annotated Code of Maryland. Such numbers are used primarily to administer and enforce the individual income tax laws and to exchange income tax information with the Internal Revenue Service, other states and other tax officials of this state. Information furnished to other agencies or persons shall be used solely for the purpose of administering tax laws or the specific laws administered by the person having statutory right to obtain it.

DUTIES AND RESPONSIBILITIES OF EMPLOYER Retain this certificate with your records. You are required to submit a copy of this certificate to the Compliance Division, Compliance Programs Section, 301 West Preston Street, Baltimore, MD 21201, when received if:

1. you have any reason to believe this certificate is incorrect;
2. the employee claims more than 10 exemptions;
3. the employee claims exemptions from withholding because he/she had no tax liability for the preceding tax year, expects to incur no tax liability this year and the wages are expected to exceed $200 a week; or
4. the employee claims exemptions from withholding on the basis of nonresidence.

Upon receipt of any exemption certificate (Form MW 507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the comptroller, the employer must send any new certificate from the employee to the comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 above, a new exemption certificate must be filed by February 15th of the following year.

DUTIES AND RESPONSIBILITIES OF EMPLOYEE If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding exemption certificate in effect, the employee shall file a new withholding exemption certificate with the employer within 10 days after the change occurs.

For additional information please call 410-767-1300 or toll-free at 1-800-492-1751 or visit our website at **www.marylandtaxes.com**

FORM VA-4

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF TAXATION

PERSONAL EXEMPTION WORKSHEET

(See back for instructions)

1. If you wish to claim yourself, write "1" .....
2. If you are married and your spouse is not claimed on his or her own certificate, write "1" .....
3. Write the number of dependents you will be allowed to claim on your income tax return (do not include your spouse) .....
4. Subtotal Personal Exemptions (add lines 1 through 3) .....
5. Exemptions for age
   (a) If you will be 65 or older on January 1, write "1" .....
   (b) If you claimed an exemption on line 2 and your spouse will be 65 or older on January 1, write "1" .....
6. Exemptions for blindness
   (a) If you are legally blind, write "1" .....
   (b) If you claimed an exemption on line 2 and your spouse is legally blind, write "1" .....
7. Subtotal exemptions for age and blindness (add lines 5 through 6) .....
8. Total of Exemptions - add line 4 and line 7 .....

Detach here and give the certificate to your employer. Keep the top portion for your records

FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE

Your social security number	Name

Street Address

City	State	ZIP Code

COMPLETE THE APPLICABLE LINES BELOW

1. If subject to withholding, enter the number of exemptions claimed on:
   (a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet .....
   (b) Subtotal of Exemptions for Age and Blindness - line 7 of the Personal Exemption Worksheet .....
   (c) Total Exemptions - line 8 of the Personal Exemption Worksheet .....
2. Enter the amount of **additional** withholding requested (see instructions) .....
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions (check here) ..... ☐

Signature _____ Date _____

EMPLOYER: Keep exemption certificates with your records. If you believe the employee has claimed too many exemptions, notify the Department of Taxation, P.O. Box 1115, Richmond, Virginia 23218-1115, telephone (804) 367-8037.

VA DEPT OF TAXATION
2601064 REV 10/04

FORM VA-4
INSTRUCTIONS

Use this form to notify your employer whether you are subject to Virginia income tax withholding and how many exemptions you are allowed to claim. You must file this form with your employer when your employment begins. If you do not file this form, your employer must withhold Virginia income tax as if you had no exemptions.

PERSONAL EXEMPTION WORKSHEET

You may not claim more personal exemptions on form VA-4 than you are allowed to claim on your income tax return unless you have received written permission to do so from the Department of Taxation.

Line 1. You may claim an exemption for yourself.

Line 2. You may claim an exemption for your spouse if he or she is not already claimed on his or her own certificate.

Line 3. Enter the number of dependents you are allowed to claim on your income tax return.
NOTE: A spouse is not a dependent.

Line 5. If you will be age 65 or over by January 1, you may claim one exemption on Line 5(a). If you claim an exemption for your spouse on Line 2, and your spouse will also be age 65 or over by January 1, you may claim an additional exemption on Line 5(b).

Line 6. If you are legally blind, you may claim an exemption on Line 6(a). If you claimed an exemption for your spouse on Line 2, and your spouse is legally blind, you may claim an exemption on Line 6(b).

FORM VA-4

Be sure to enter your social security number, name and address in the spaces provided.

Line 1. If you are subject to withholding, enter the number of exemptions from:

(a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet

(b) Subtotal of Exemptions for Age and Blindness - line 7 of the Personal Exemption Worksheet

(c) Total Exemptions - line 8 of the Personal Exemption Worksheet

Line 2. If you wish to have additional tax withheld, and your employer has agreed to do so, enter the amount of additional tax on this line.

Line 3. If you are not subject to Virginia withholding, check the box on this line. You are not subject to withholding if you meet any one of the conditions listed below. Form VA-4 must be filed with your employer for each calendar year for which you claim exemption from Virginia withholding.

(a) You had no liability for Virginia income tax last year and you do not expect to have any liability for this year.

(b) You expect your Virginia adjusted gross income to be less than:

Prior to 1/1/2005		On or After 1/1/2005	
Single	$5,000	Single	$7,000
Married, filing a joint or combined return	$8,000	Married, filing a joint or combined return	$14,000
Married, filing a separate return	$4,000	Married, filing a separate return	$7,000

(c) You live in Kentucky or the District of Columbia and commute on a daily basis to your place of employment in Virginia.

(d) You are a domiciliary or legal resident of Maryland, Pennsylvania or West Virginia whose only Virginia source income is from salaries and wages and such salaries and wages are subject to income taxation by your state of domicile.

Standard Form 1199A
(Rev. June 1987)
Prescribed by Treasury
Department
Treasury Dept. Cir. 1076

FOR SALE BY THE SUPERINTENDENT OF DOCUMENTS. US GOVERNMENT PRINTING OFFICE
WASHINGTON, DC 20402 STOCK NO. 048-000-00363-0

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY | STATE | ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER
Prefix | Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire
- ☐ Mil. Survivor
- ☐ Other *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE | AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER | CHECK DIGIT

☐☐☐☐--☐☐☐☐ ☐

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

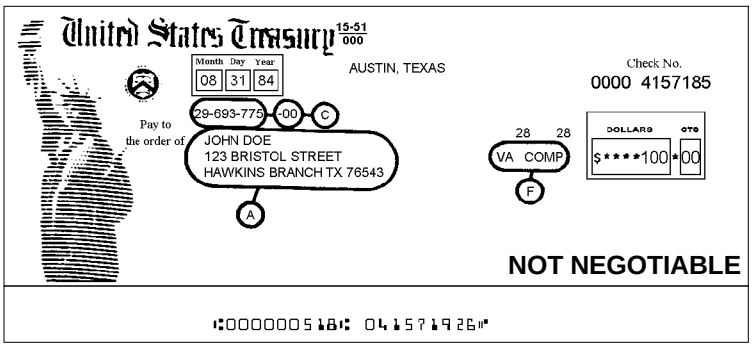
THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:



(A) Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.

(C) Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.

(F) Type of payment is printed to the left of the amount.

SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

FEHB
Federal Employees Health Benefits Program

Health Benefits Election Form

Form Approved:
OMB No. 3206-0160

Uses for Standard Form (SF) 2809

Use this form to:

- Enroll or reenroll in the FEHB Program; or
- Elect not to enroll in the FEHB Program *(employees only)*; or
- Change your FEHB enrollment; or
- Cancel your FEHB enrollment; or
- Suspend your FEHB enrollment *(annuitants or former spouses only)*.

Who May Use SF 2809

1. Employees eligible to enroll in or currently enrolled in the FEHB Program, including temporary employees eligible under 5 U.S.C. 8906a. ***Employees automatically participate in premium conversion unless they waive it, see page 7.***
2. Annuitants (other than Civil Service Retirement System [CSRS] and Federal Employees Retirement System [FERS] annuitants) eligible to enroll in or currently enrolled in the FEHB Program, including individuals receiving monthly compensation from the Office of Workers' Compensation Programs (OWCP).

   Note: *Civil Service Retirement System (CSRS) and Federal Employees Retirement System (FERS) annuitants and former spouses and children of CSRS/FERS annuitants --* ***Do not use this form.*** *Instead, call the Retirement Information Office toll-free at 1-888-767-6738. Customers within the local calling distance to Washington, DC, should call 202-606-0500.*

3. Former spouses eligible to enroll in or currently enrolled in the FEHB Program under the Spouse Equity law or similar statutes.
4. Individuals eligible for Temporary Continuation of Coverage (TCC) under the FEHB Program, including:
   - Former employees (who separated from service);
   - Children who lose FEHB coverage; and
   - Former spouses who are not eligible for FEHB under item 3 above.

Instructions for Completing SF 2809

Type or Print Firmly. We have not provided instructions for those items that have an explanation on the form.

Part A — Enrollee and Family Member Information.

You must complete this part.

Item 2. See the Privacy Act and Public Burden Statements on page 5.

Item 5. If you are separated but not divorced, you are still married.

Item 7. If you have Medicare, show which Parts you have. If you complete this form after November 15, 2005, also indicate whether you have prescription drug coverage under the Medicare Part D program.

Item 8. TRICARE is a health care program for active duty and retired members of the uniformed services, their families, and survivors. This includes TRICARE for Life for members 65 and over.

Item 9. If you have other group insurance (private, state, Medicaid, CHAMPVA), check the box.

Item 10. Write the name of any other insurance you have.

Complete information for family members only if your enrollment is for Self and Family. (If you need extra space for additional family members, list them on a separate sheet and attach.)

Item 13. Please provide Social Security Numbers for your dependents if available. If not available, leave blank; benefits will not be withheld. (See Privacy Act Statement on page 5.)

Item 16. Provide the code which indicates the relationship of each eligible family member to you.

Code	Family Relationship
01	Spouse
19	Unmarried dependent child under age 22
09	Adopted Child
17	Stepchild
10	Foster Child
99	Unmarried disabled child over age 22 incapable of self support because of a physical or mental disability that began before age 22.

Item 18. If a family member has Medicare, show which Parts he/she has on the line with his/her name. If you complete this form after November 15, 2005, also indicate whether you have prescription drug coverage under the Medicare Part D program.

Item 19. If a family member has TRICARE, see item 8. Check the box.

Item 20. If a family member has other group insurance (private, state, Medicaid), check the box.

Item 21. Give the name of any other insurance this family member has.

Family Members Eligible for Coverage

Unless you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment include your spouse and your unmarried dependent children under age 22. Eligible children include your legitimate or adopted children; and recognized children born out of wedlock, stepchildren or foster children, if they live with you in a regular parent-child relationship. A recognized child born out of wedlock also may be included if a judicial determination of support has been obtained or you show that you provide regular and substantial support for the child.

Other relatives (for example, your parents) are ***not*** eligible for coverage even if they live with you and are dependent upon you.

- If you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment are the unmarried dependent natural or adopted children under age 22 of both you and your former or deceased spouse.
- Children whose marriage ends before they reach age 22 become eligible for coverage under your Self and Family enrollment from the date the marriage ends until they reach age 22.

In some cases, an unmarried, disabled child who is 22 years old or older is eligible for coverage under your Self and Family enrollment if you provide adequate medical certification of a mental or physical handicap that existed before his or her 22nd birthday and renders the child incapable of self-support.

Note: Your employing office can give you additional details about family member eligibility including any certification or documentation that may be required for coverage. "Employing office" means the office of an agency or retirement system that is responsible for health benefits actions for an employee, annuitant, former spouse eligible for coverage under the Spouse Equity provisions, or individual eligible for TCC.

Part B — Present Plan.

You must complete this part if you are changing, cancelling, or suspending your enrollment.

Item 1. Enter the name of the plan you are enrolled in from the front cover of the plan brochure.

Item 2. Enter your present enrollment code.

Part C — New Plan.

Complete this part to enroll or change your enrollment in the FEHB Program.

Items 1 and 2. Enter the plan name and enrollment code from the front cover of the brochure of the plan you want to be enrolled in. The enrollment code shows the plan and option you are electing and whether you are enrolling for Self Only or Self and Family.

To enroll in a Health Maintenance Organization (HMO), you must live (or in some cases work) in a geographic area specified by the carrier.

To enroll in an employee organization plan, you must be or become a member of the plan's sponsoring organization, as specified by the carrier.

Your signature in Part H authorizes deductions from your salary, annuity, or compensation to cover your cost of the enrollment you elect in this item, unless you are required to make direct payments to the employing office.

Part D — Event Code.

Item 1. Enter the event code that permits you to enroll, change, or cancel based on a qualifying life event (QLE) from the Table of Permissible Changes in Enrollment that applies to you.

Explanation of Table of Permissible Changes in Enrollment

The tables on pages 7 through 14 illustrate when: an employee who participates in premium conversion; annuitant; former spouse; person eligible for TCC; or employee who waived participation in premium conversion may enroll or change enrollment. The tables show those permissible events that are found in the regulations at 5 CFR Parts 890 and 892.

The tables have been organized by enrollee category. Each category is designated by a number, which identifies the enrollee group, as follows:

1. Employees who participate in premium conversion
2. Annuitants (other than CSRS/FERS annuitants), including individuals receiving monthly compensation from the Office of Workers' Compensation Programs
3. Former spouses eligible for coverage under the Spouse Equity provision of FEHB law
4. TCC enrollees
5. Employees who waived participation in premium conversion

Following each number is a letter, which identifies a specific permissible event; for example, the event code "1A" refers to the initial opportunity to enroll for an employee who elected to participate in premium conversion.

Item 2. Enter the date of the permissible event using numbers to show month, day, and complete year; e.g., 06/30/2004. If you are electing to enroll, enter the date you became eligible to enroll (for example, the date your appointment began). If you are making an open season enrollment or change, enter the date on which the open season begins.

Part E — Election NOT to Enroll.

Place an "X" in the box provided only if you are an employee and you do NOT wish to enroll in the FEHB Program. ***Be sure to read the information below in the paragraph titled*** *Employees Who Elect Not to Enroll or Who Cancel Their Enrollment.*

Part F — Cancellation.

Place an "X" in the box provided only if you wish to cancel your FEHB enrollment. Also enter your present enrollment code in ***Part B. Be sure to read the information below in the paragraph titled*** *Employees Who Elect Not to Enroll or Who Cancel Their Enrollment.*

Note For Parts E and F. *If you are not enrolling or cancelling your enrollment because you are covered as a spouse or child under another FEHB plan, please write the enrollee's name, social security number, and FEHB enrollment code in REMARKS.*

Cancellation of Enrollment

Employees participating in premium conversion may cancel their FEHB enrollment only during the open season or when they experience a qualifying life event. Employees who waived participation in premium conversion, annuitants, former spouses, and individuals enrolled under TCC may cancel their enrollment at any time. However, if you cancel, neither you nor any family member covered by your enrollment are entitled to a 31-day temporary extension of coverage, or to convert to an individual, nongroup policy. Moreover, family members who lose coverage because of your cancellation are not eligible for TCC. Be sure to read the additional information below about cancelling your enrollment.

Employees Who Elect Not to Enroll or Who Cancel Their Enrollment

To be eligible for an FEHB enrollment after you retire, you must retire:

- Under a retirement system for Federal civilian employees, and
- On an immediate annuity.

In addition, you must be currently enrolled in a plan under the FEHB Program and must have been enrolled (or covered as a family member) in a plan under the Program for:

- The 5 years of service immediately before retirement (i.e., commencing date of annuity entitlement), or
- If fewer than 5 years, all service since your first opportunity to enroll. (Generally, your first opportunity to enroll is within 60 days after your first appointment [in your Federal career] to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

If you do not enroll at your first opportunity or if you cancel your enrollment, you may later enroll or reenroll only under the circumstances explained in the table beginning on page 7. Some employees delay their enrollment or reenrollment until they are nearing 5 years before retirement in order to qualify for FEHB coverage as a retiree; however, there is always the risk that they will retire earlier than expected and not be able to meet the 5-year requirement for continuing FEHB coverage into retirement. Please understand that when you elect not to enroll or cancel your enrollment ***you are voluntarily accepting this risk***. An alternative would be to enroll in or change to a lower cost plan so that you meet the requirements for continuation of your FEHB enrollment after retirement.

Note for temporary [under 5 U.S.C. 8906a] employees eligible for FEHB without a Government contribution: *Your decision not to enroll or to cancel your enrollment will* ***not*** *affect your future eligibility to continue FEHB enrollment after retirement.*

Annuitants Who Cancel Their Enrollment

CSRS and FERS annuitants and their dependents should not use this form but call 1-888-767-6738, or 202-606-0500 within the Washington, D.C. area.

Generally, you cannot reenroll as an annuitant unless you are continuously covered as a family member under another person's enrollment in the FEHB Program during the period between your cancellation and reenrollment. Your employing office or retirement system can advise you on events that allow eligible annuitants to reenroll. If you cancel your enrollment because you are covered under another FEHB enrollment, you can reenroll from 31 days before through 60 days after you lose that coverage under the other enrollment.

If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.

Former Spouses (Spouse Equity) Who Cancel Their Enrollment

Generally, if you cancel your enrollment in the FEHB Program, you cannot reenroll as a former spouse. However, if you stop the enrollment because you acquire other FEHB coverage as a new spouse or employee, your right to FEHB coverage under the Spouse Equity provisions continues. You may reenroll as a former spouse from 31 days before through 60 days after you lose coverage under the other FEHB enrollment.

If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.

Temporary Continuation of Coverage Enrollees Who Cancel Their Enrollment

If you cancel your TCC enrollment, you cannot reenroll. Your family members who lose coverage because of your cancellation cannot enroll for TCC in their own right nor can they convert to a nongroup policy. However, family members who are Federal employees or annuitants may enroll in the FEHB Program when you cancel your coverage if they are eligible for FEHB coverage in their own right.

Note 1: *If you become covered by a regular enrollment in the FEHB Program, either in your own right or under the enrollment of someone else, your TCC enrollment is suspended. You will need to send documentation of the new enrollment to the employing office maintaining your TCC enrollment so that they can stop the TCC enrollment. If your new FEHB coverage stops before the TCC enrollment would have expired, the TCC enrollment can be reinstated for the remainder of the original eligibility period (18 months for separated employees or 36 months for dependents who lose coverage).*

Note 2: *Former spouses (Spouse Equity) and* TCC *enrollees who fail to pay their premiums within specified timeframes are considered to have voluntarily cancelled their enrollment.*

Part G — Suspension.

CSRS and FERS annuitants and their dependents should not use this form but call 1-888-767-6738, or 202-606-0500 within the Washington, D.C. area.

Place an "X" in the box only if you are an annuitant or former spouse and wish to suspend your FEHB enrollment. Also enter your present enrollment code in Part B.

You may suspend your FEHB enrollment because you are enrolling in one of the following programs:

- A Medicare HMO or Medicare Advantage plan,
- Medicaid or similar State-sponsored program of medical assistance for the needy,
- TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), or
- CHAMPVA

You can reenroll in the FEHB Program if your other coverage ends. If your coverage ends ***involuntarily***, you can reenroll 31 days before through 60 days after loss of coverage. If your coverage ends ***voluntarily*** because you disenroll, you can reenroll during the next open season.

You must submit documentation of eligibility for coverage under the non-FEHB Program to the office that maintains your enrollment. That office must enter in REMARKS the reason for your suspension.

Part H — Signature.

Your agency, retirement system, or office maintaining your enrollment cannot process your request unless you complete this part.

If you are registering for someone else under a written authorization from him or her to do so, sign your name in Part H and attach the written authorization.

If you are registering for a former spouse eligible for coverage under the Spouse Equity provisions or for an individual eligible for TCC as his or her court-appointed guardian, sign your name in Part H and attach evidence of your court-appointed guardianship.

Part I - Agency or Retirement System Information and Remarks.

Leave this section blank as it is for agency or retirement system use only.

Guides to Federal Employees Health Benefits Plans (FEHB Guides) and Plan Brochures

FEHB Guides contain plan and rate information. Be sure you have the correct guide for your enrollment category since more than one guide is used.

FEHB Plan brochures contain detailed information about plan benefits and the contractual description of coverage.

Where to Obtain FEHB Guides and Brochures

FEHB Guides and plan brochures may be available from your employing office or the office that maintains your enrollment.

Your plan will send you its brochure before the beginning of each contract year. You may also get copies of plan brochures by contacting the plans directly at the telephone numbers shown in the FEHB Guide. The FEHB Guide also shows which plans have their own website.

The FEHB Guide, plan brochures, and other information, including links to plan websites, are available on the FEHB website at ***http://www.opm.gov/insure/health***.

Electronic Enrollments

Many agencies use automated systems that allow their employees to make changes using a touch-tone telephone, or a computer instead of a form. This may be Employee Express or some other automated system. If you are not sure whether the electronic enrollment option is available to you, contact your employing office.

Dual Enrollment

Normally, you are not eligible to enroll if you are covered as a family member under someone else's enrollment in the FEHB Program. However, such dual enrollments may be permitted under certain circumstances in order to:

- Protect the interests of children who otherwise would lose coverage as family members, or
- Enable an employee who is under age 22 and covered under a parent's enrollment and becomes the parent of a child to enroll for Self and Family coverage.

No person (enrollee or family member) is entitled to receive benefits under more than one enrollment in the Program. Each enrollee must notify his or her plan of the names of the persons to be covered under his or her enrollment who are not covered under the other enrollment.

Temporary Continuation of Coverage (TCC)

The employing office must notify a former employee of his or her eligibility for TCC. The enrollee, child, former spouse, or their representative must notify the employing office when a child or former spouse becomes eligible.

- For the eligible child of an enrollee, the enrollee must notify the employing office within ***60 days*** after the qualifying event occurs; e.g., child reaches age 22.
- For the eligible former spouse of an enrollee, the enrollee or the former spouse must notify the employing office within ***60 days*** after the former spouse's change in status; e.g., the date of the divorce.

An individual eligible for TCC who wants to continue FEHB coverage may choose any plan for which he or she is eligible, option, and type of enrollment. The time limit for a former employee, child, or former spouse to enroll with the employing office is within ***60 days*** after the qualifying life event, or receiving notice of eligibility, whichever is later.

Note:

- *If someone other than the enrollee notifies the employing office of the child's eligibility for TCC within the specified time period, the child's opportunity to enroll ends 60 days after the qualifying event.*
- *If someone other than the enrollee or the former spouse notifies the employing office of the former spouse's eligibility for continued coverage within the specified time period, the former spouse's opportunity to enroll ends 60 days after the change in status.*

Effective Dates

Except for open season, most enrollments and changes of enrollment are effective on the first day of the pay period after the employing office receives this form and that follows a pay period during any part of which the employee is in pay status. Your employing office can give you the specific date on which your enrollment or enrollment change will take effect.

Note 1: *If you are changing your enrollment from Self and Family to Self Only so that your spouse can enroll for Self Only, you should coordinate the effective date of your spouse's enrollment with the effective date of your enrollment change to avoid a gap in your spouse's coverage.*

Note 2: *If you are cancelling your enrollment and intend to be covered under someone else's enrollment at the time you cancel, you should coordinate the effective date of your cancellation with the effective date of your new coverage to avoid a gap in your coverage.*

Privacy Act Statement

The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program (FEHB) under Chapter 89, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB Program. Executive Order 9397 (November 22, 1943) allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

Agencies other than the OPM may have further routine uses for disclosure of information from the records system in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

Public Burden Statement

We think this form takes an average of 30 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, OPM Forms Officer, (3206-0160), Washington, D.C. 20415-7900. The OMB number, 3206-0160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Federal Employees Receiving Premium Conversion Tax Benefits
Table of Permissible Changes in FEHB Enrollment and Premium Conversion Election

Premium Conversion allows employees who are eligible for FEHB the opportunity to pay for their share of FEHB premiums with pre-tax dollars. Premium conversion plans are governed by Section 125 of the Internal Revenue Code, and IRS rules govern when a participant may change his or her election outside of the annual open season. **All employees who enroll in the FEHB Program automatically receive premium conversion tax benefits,** unless they waive participation. When an employee experiences a qualifying life event (QLE) as described below, changes to the employee's FEHB coverage **(including change to self only and cancellation)** and premium conversion election may be permitted, so long as they are **because of and consistent with** the QLEs. For more information about premium conversion, please visit *www.opm.gov/insure/health.*

Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election		***FEHB Enrollment Change that May Be Permitted***				***Premium Conversion Election Change that May Be Permitted***		***Time Limits in which Change May Be Permitted***
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*[1]	*Participate*	*Waive*	*When You Must File Health Benefits Election Form With Your Employing Office*
1	**Employee electing to receive or receiving premium conversion tax benefits**							
1A	Initial opportunity to enroll, for example: • New employee • Change from excluded position • Temporary employee who completes 1 year of service and is eligible to enroll under 5 USC 8906a	Yes	N/A	N/A	N/A	***Automatic Unless Waived***	Yes	Within 60 days after becoming eligible
1B	Open Season	Yes	Yes	Yes	Yes	Yes	Yes	As announced by OPM
1C	Change in family status that results in increase or decrease in number of eligible family members, for example: • Marriage, divorce, annulment, legal separation • Birth, adoption, acquiring foster child or stepchild, issuance of court order requiring employee to provide coverage for child • Last dependent child loses coverage, for example, child reaches age 22 or marries, stepchild moves out of employee's home, disabled child becomes capable of self-support, child acquires other coverage by court order • Death of spouse or dependent	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after change in family status
		Employees may enroll or change beginning 31 days before the event.						
1D	Any change in employee's employment status that could result in entitlement to coverage, for example: • Reemployment after a break in service of more than 3 days • Return to pay status from nonpay status, or return to receiving pay sufficient to cover premium withholdings, if coverage terminated *(If coverage did not terminate, see 1G.)*	Yes	N/A	N/A	N/A	***Automatic Unless Waived***	Yes	Within 60 days after employment status change
1E	Any change in employee's employment status that could affect cost of insurance, including: • Change from temporary appointment with eligibility for coverage under 5 USC 8906a to appointment that permits receipt of government contribution • Change from full time to part-time career or the reverse	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after employment status change
1F	Employee restored to civilian position after serving in uniformed services.[2]	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after return to civilian position

Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election		FEHB Enrollment Change that May Be Permitted				Premimum Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*	*Participate*	*Waive*	*When You Must File Health Benefits Election Form With Your Employing Office*
1G	Employee, spouse or dependent: • Begins nonpay status or insufficient pay[3] or • Ends nonpay status or insufficient pay if coverage continued • *(If employee's coverage terminated, see 1D.)* • *(If spouse's or dependent's coverage terminated, see 1M.)*	No	No	No	Yes	Yes	Yes	Within 60 days after employment status change
1H	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Yes	Yes	Yes	Within 60 days after receiving notice from employing office
1I	Employee (or covered family member) enrolled in FEHB health maintenance organization (HMO) moves or becomes employed outside the geographic area from which the FEHB carrier accepts enrollments or, if already outside the area, moves further from this area.[4]	N/A	Yes	Yes	N/A *(see 1M)*	No *(see 1M)*	No *(see 1M)*	Upon notifying employing office of move
1J	Transfer from post of duty within a State of the United States or the District of Columbia to post of duty outside a State of the United States or District of Columbia, or reverse.	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after arriving at new post
		Employees may enroll or change beginning 31 days before leaving the old post of duty.						
1K	Separation from Federal employment when the employee or employee's spouse is pregnant.	Yes	Yes	Yes	N/A	N/A	N/A	During employee's final pay period
1L	Employee becomes entitled to Medicare and wants to change to another plan or option. [5]	No	No	Yes *(Changes may be made only once.)*	N/A *(see 1M)*	N/A *(see 1M)*	N/A *(see 1M)*	Any time beginning on the 30th day before becoming eligible for Medicare
1M	Employee or eligible family member loses coverage under FEHB or another group insurance plan including the following: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment • Loss of coverage due to termination of membership in employee organization sponsoring the FEHB plan[6] • Loss of coverage under another federally-sponsored health benefits program, including: TRICARE, Medicare, Indian Health Service • Loss of coverage under Medicaid or similar State-sponsored program of medical assistance for the needy • Loss of coverage under a non-Federal health plan, including foreign, state or local government, private sector • Loss of coverage due to change in worksite or residence *(Employees in an FEHB HMO, also see 1I.)*	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after loss of coverage
		Employees may enroll or change beginning 31 days before the event.						
1N	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-Federally employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area to 180 days after arriving in the new commuting area
1O	Employee or eligible family member loses coverage due to discontinuance in whole or part of FEHB plan.[7]	Yes	Yes	Yes	Yes	Yes	Yes	During open season, unless OPM sets a different time

Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election		***FEHB Enrollment Change that May Be Permitted***				***Premimum Conversion Election Change that May Be Permitted***		***Time Limits in which Change May Be Permitted***
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*	*Participate*	*Waive*	*When You Must File Health Benefits Election Form With Your Employing Office*
1P	Enrolled employee or eligible family member gains coverage under FEHB or another group insurance plan, including the following: • Medicare (Employees who become eligible for Medicare and want to change plans or options, see 1L.) • TRICARE for Life, due to enrollment in Medicare. • TRICARE due to change in employment status, including: (1) entry into active military service, (2) retirement from reserve military service under Chapter 67, title 10. • Medicaid or similar State-sponsored program of Medical assistance for the needy • Health insurance acquired due to change of worksite or residence that affects eligibility for coverage • Health insurance acquired due to spouse's or dependent's change in employment status (includes state, local, or foreign government or private sector employment).[8]	No	No	No	Yes	Yes	Yes	Within 60 days after QLE
1Q	Change in spouse's or dependent's coverage options under a non-Federal health plan, for example: • Employer starts or stops offering a different type of coverage *(If no other coverage is available, also see 1M.)* • Change in cost of coverage • HMO adds a geographic service area that now makes spouse eligible to enroll in that HMO • HMO removes a geographic area that makes spouse ineligible for coverage under that HMO, but other plans or options are available*(If no other coverage is available, see 1M)*	No	No	No	Yes	Yes	Yes	Within 60 days after QLE

(If you are a United States Postal Service employee, these rules may be different. Consult your employing office or information provided by your agency.)

1. Employees may change to self only outside of open season only if ***the QLE caused*** the enrollee to be the last eligible family member under the FEHB enrollment. Employees may cancel enrollment outside of open season only if ***the QLE caused*** the enrollee and all eligible family members to acquire other health insurance coverage.

2. Employees who enter active military service are given the opportunity to terminate coverage. Termination for this reason does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement. Additional information on the FEHB coverage of employees who return from active military service will be forthcoming.

3. Employees who begin nonpay status or insufficient pay ***must*** be given an opportunity to elect to continue or terminate coverage. A termination differs from a cancellation as it allows conversion to nongroup coverage and does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement.

4. This code reflects the FEHB regulation that gives employees enrolled in an FEHB HMO who ***change from self only to self and family or from one plan or option to another*** a different timeframe than that allowed under 1M. For change to self-only, cancellation, or change in premium conversion status, see 1M.

5. This code reflects the FEHB regulation that gives employees enrolled in FEHB a one-time opportunity to change plans or options under a different timeframe than that allowed by 1P. For change to self only, cancellation, or change in premium conversion status, see 1P.

6. If employee's membership terminates (e.g., for failure to pay membership dues), the employee organization will notify the agency to ***terminate*** the enrollment.

7. Employee's failure to select another FEHB plan is deemed a cancellation for purposes of meeting the requirements for continuing coverage after retirement.

8. Under IRS rules, this includes start/stop of employment or nonpay status, strike or lockout, and change in worksite.

Tables of Permissible Changes in FEHB Enrollment for Individuals Who Are Not Participating in Premium Conversion

Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time

QLE's That Permit Enrollment or Change		*Change Permitted*			*Time Limits*
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
2	**Annuitant (Includes Compensationers)** ***Note for enrolled survivor annuitants:*** A change in family status based on additional family members can only occur if the additional eligible family members are family members of the deceased employee or annuitant.				
2A	Open Season	No	Yes	Yes	As announced by OPM.
2B	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after the event.
2C	Reenrollment of annuitant who cancelled FEHB enrollment to enroll in a Medicare-sponsored plan, Medicaid, or similar State-sponsored program and who later was ***involuntarily*** disenrolled from the Medicare-sponsored plan, Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment.
2D	Reenrollment of annuitant who cancelled FEHB enrollment to enroll in a Medicare-sponsored plan, Medicaid, or similar State-sponsored program and who later ***voluntarily*** disenrolls from the Medicare-sponsored plan, Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	During open season.
2E	Restoration of annuity or compensation (OWCP) payments; for example: • Disability annuitant who was enrolled in FEHB, and whose annuity terminated due to restoration of earning capacity or recovery from disability, and whose annuity is restored; • Compensationer whose compensation terminated because of recovery from injury or disease and whose compensation is restored due to a recurrence of medical condition; • Surviving spouse who was covered by FEHB immediately before survivor annuity terminated because of remarriage and whose annuity is restored; • Surviving child who was covered by FEHB immediately before survivor annuity terminated because student status ended and whose survivor annuity is restored; • Surviving child who was covered by FEHB immediately before survivor annuity terminated because of marriage and whose survivor annuity is restored.	Yes	N/A	N/A	Within 60 days after the retirement system or OWCP mails a notice of insurance eligibility.
2F	Annuitant or eligible family member loses FEHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
2G	Annuitant or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see events 2C and 2D); • Loss of coverage under a non-Federal health plan.	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
2H	Annuitant or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
2I	Annuitant or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
2J	Employee in an overseas post of duty retires or dies.	No	Yes	Yes	Within 60 days after retirement or death.
2K	An enrolled annuitant separates from duty after serving 31 days or more in a uniformed service.	N/A	Yes	Yes	Within 60 days after separation from the uniformed service.
2L	On becoming eligible for Medicare. (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
2M	Annuitant's annuity is insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Employing office will advise annuitant of the options.
3	**Former Spouse Under The Spouse Equity Provisions** ***Note:*** Former spouse may change to Self and Family only if family members are also eligible family members of the employee or annuitant.				
3A	Initial opportunity to enroll. Former spouse must be eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615), as amended, the Intelligence Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).	Yes	N/A	N/A	Generally, must apply within 60 days after dissolution of marriage. However, if a retiring employee elects to provide a former spouse annuity or insurable interest annuity for the former spouse, the former spouse must apply within 60 days after OPM's notice of eligibility for FEHB. May enroll any time after employing office establishes eligibility.
3B	Open Season.	No	Yes	Yes	As announced by OPM.
3C	Change in family status based on addition of family members who are also eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after change in family status.
3D	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare-sponsored plan, Medicaid, or similar State-sponsored program and who later was ***involuntarily*** disenrolled from the Medicare-sponsored plan, Medicaid, or similar State-sponsored program.	May reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment.
3E	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare-sponsored plan, Medicaid, or similar State-sponsored program and who later ***voluntarily*** disenrolls from the Medicare-sponsored plan, Medicaid, or similar State-sponsored program.	May reenroll	N/A	N/A	During open season.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
3F	Former spouse or eligible child loses FEHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.
3G	Enrolled former spouse or eligible child loses coverage under another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see 3D and 3E); • Loss of coverage under a non-Federal health plan.	N/A	Yes	Yes	From 31 days before through 60 days after loss of coverage.
3H	Former spouse or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
3I	Former spouse or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
3J	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning the 30th day before becoming eligible for Medicare.
3K	Former spouse's annuity is insufficient to make FEHB withholdings for plan in which enrolled.	No	No	Yes	Retirement system will advise former spouse of options.
4	**Temporary Continuation of Coverage (TCC) For Eligible Former Employees, Former Spouses, and Children.** *Note:* Former spouse may change to Self and Family only if family members are also eligible family members of the employee or annuitant.				
4A	Opportunity to enroll for continued coverage under TCC provisions: • Former employee • Former spouse • Child who ceases to qualify as a family member	 Yes Yes Yes	 Yes N/A N/A	 Yes N/A N/A	Within 60 days after the qualifying event, or receiving notice of eligibility, whichever is later.
4B	Open Season: • Former employee • Former spouse • Child who ceases to qualify as a family member	 No No No	 Yes Yes Yes	 Yes Yes Yes	As announced by OPM.
4C	Change in family status (except former spouse); for example, marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after event.
4D	Change in family status of former spouse, based on addition of family members who are eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after event.
4E	Reenrollment of a former employee, former spouse, or child whose TCC enrollment was terminated because of other FEHB coverage and who loses the other FEHB coverage before the TCC period of eligibility (18 or 36 months) expires.	May reenroll	N/A	N/A	From 31 days before through 60 days after the event. Enrollment is retroactive to the date of the loss of the other FEHB coverage.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
3F	Former spouse or eligible child loses FEHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.
3G	Enrolled former spouse or eligible child loses coverage under another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see 3D and 3E); • Loss of coverage under a non-Federal health plan.	N/A	Yes	Yes	From 31 days before through 60 days after loss of coverage.
3H	Former spouse or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
3I	Former spouse or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
3J	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning the 30th day before becoming eligible for Medicare.
3K	Former spouse's annuity is insufficient to make FEHB withholdings for plan in which enrolled.	No	No	Yes	Retirement system will advise former spouse of options.
4	**Temporary Continuation of Coverage (TCC) For Eligible Former Employees, Former Spouses, and Children.** *Note:* Former spouse may change to Self and Family only if family members are also eligible family members of the employee or annuitant.				
4A	Opportunity to enroll for continued coverage under TCC provisions: • Former employee • Former spouse • Child who ceases to qualify as a family member	 Yes Yes Yes	 Yes N/A N/A	 Yes N/A N/A	Within 60 days after the qualifying event, or receiving notice of eligibility, whichever is later.
4B	Open Season: • Former employee • Former spouse • Child who ceases to qualify as a family member	 No No No	 Yes Yes Yes	 Yes Yes Yes	As announced by OPM.
4C	Change in family status (except former spouse); for example, marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after event.
4D	Change in family status of former spouse, based on addition of family members who are eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after event.
4E	Reenrollment of a former employee, former spouse, or child whose TCC enrollment was terminated because of other FEHB coverage and who loses the other FEHB coverage before the TCC period of eligibility (18 or 36 months) expires.	May reenroll	N/A	N/A	From 31 days before through 60 days after the event. Enrollment is retroactive to the date of the loss of the other FEHB coverage.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
5E	Separation from Federal employment when the employee is or employee's spouse is pregnant.	Yes	Yes	Yes	Enrollment or change must occur during final pay period of employment.
5F	Transfer from a post of duty within the United States to a post of duty outside the United States, or reverse.	Yes	Yes	Yes	From 31 days before leaving old post through 60 days after arriving at new post.
5G	Employee or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment; • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-Federal health plan.	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
5H	Enrollee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
5I	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-federally employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area through 180 days after arriving in the new commuting area.
5J	Employee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside the area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
5K	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
5L	Temporary employee completes one year of continuous service in accordance with 5 U.S.C. Section 8906a.	Yes	N/A	N/A	Within 60 days after becoming eligible.
5M	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Within 60 days after receiving notice from employing office.

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 | 4. Sex ☐ M ☐ F | 5. Are you married? ☐ Yes ☐ No

6. Home mailing address *(including ZIP Code)* | 7. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | 8. TRICARE ☐ | 9. Other insurance ☐

10. Name of insurance | 11. Insurance policy no.

12. Name of family member *(last, first, middle initial)* | 13. Social Security number | 14. Date of birth | 15. Sex ☐ M ☐ F | 16. Relationship code

17. Address *(if different from enrollee)* | 18. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | 19. TRICARE ☐ | 20. Other insurance ☐

21. Name of insurance | 22. Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐

Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐

Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐

Name of insurance | Insurance policy no.

Part B - Present Plan

1. Plan name | 2. Enrollment code

Part C - New Plan

1. Plan name | 2. Enrollment code

Part D - Event Code

1. Event code | 2. Date of event

Part E - Employees Only (Election NOT to Enroll)

☐ 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

☐ 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 (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)* | 3. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS

1. Date received | 2. Effective date of action | 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

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
4. Sex ☐ M ☐ F
5. Are you married? ☐ Yes ☐ No
6. Home mailing address *(including ZIP Code)*
7. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
8. TRICARE ☐
9. Other insurance ☐
10. Name of insurance
11. Insurance policy no.

12. Name of family member *(last, first, middle initial)*
13. Social Security number
14. Date of birth
15. Sex ☐ M ☐ F
16. Relationship code
17. Address *(if different from enrollee)*
18. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
19. TRICARE ☐
20. Other insurance ☐
21. Name of insurance
22. Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Part B - Present Plan

1. Plan name
2. Enrollment code

Part C - New Plan

1. Plan name
2. Enrollment code

Part D - Event Code

1. Event code
2. Date of event

Part E - Employees Only (Election NOT to Enroll)

☐ 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

☐ 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 (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)*
3. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS

1. Date received
2. Effective date of action
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

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
4. Sex ☐ M ☐ F
5. Are you married? ☐ Yes ☐ No
6. Home mailing address *(including ZIP Code)*
7. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
8. TRICARE ☐
9. Other insurance ☐
10. Name of insurance
11. Insurance policy no.

12. Name of family member *(last, first, middle initial)*
13. Social Security number
14. Date of birth
15. Sex ☐ M ☐ F
16. Relationship code
17. Address *(if different from enrollee)*
18. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
19. TRICARE ☐
20. Other insurance ☐
21. Name of insurance
22. Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Part B - Present Plan

1. Plan name
2. Enrollment code

Part C - New Plan

1. Plan name
2. Enrollment code

Part D - Event Code

1. Event code
2. Date of event

Part E - Employees Only (Election NOT to Enroll)

☐ 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

☐ 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 (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)*
3. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS

1. Date received __/__/____
2. Effective date of action __/__/____
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 ( )

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 | 4. Sex ☐ M ☐ F | 5. Are you married? ☐ Yes ☐ No

6. Home mailing address *(including ZIP Code)* | 7. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | 8. TRICARE ☐ | 9. Other insurance ☐

10. Name of insurance | 11. Insurance policy no.

12. Name of family member *(last, first, middle initial)* | 13. Social Security number | 14. Date of birth | 15. Sex ☐ M ☐ F | 16. Relationship code

17. Address *(if different from enrollee)* | 18. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | 19. TRICARE ☐ | 20. Other insurance ☐

21. Name of insurance | 22. Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐

Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐

Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐

Name of insurance | Insurance policy no.

Part B - Present Plan

1. Plan name
2. Enrollment code

Part C - New Plan

1. Plan name
2. Enrollment code

Part D - Event Code

1. Event code
2. Date of event

Part E - Employees Only (Election NOT to Enroll)

☐ 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

☐ 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 (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)*
3. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS

1. Date received
2. Effective date of action
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

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
4. Sex ☐ M ☐ F
5. Are you married? ☐ Yes ☐ No
6. Home mailing address *(including ZIP Code)*
7. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
8. TRICARE ☐
9. Other insurance ☐
10. Name of insurance
11. Insurance policy no.

12. Name of family member *(last, first, middle initial)*
13. Social Security number
14. Date of birth
15. Sex ☐ M ☐ F
16. Relationship code
17. Address *(if different from enrollee)*
18. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D
19. TRICARE ☐
20. Other insurance ☐
21. Name of insurance
22. Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security number | Date of birth | Sex ☐ M ☐ F | Relationship code
Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐
Name of insurance | Insurance policy no.

Part B - Present Plan

1. Plan name
2. Enrollment code

Part C - New Plan

1. Plan name
2. Enrollment code

Part D - Event Code

1. Event code
2. Date of event

Part E - Employees Only (Election NOT to Enroll)

☐ 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

☐ 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 (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)*
3. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS

1. Date received
2. Effective date of action
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

FEGLI
Federal Employees Group Life Insurance

Life Insurance Election

Federal Employees' Group Life Insurance Program

See Privacy Act Statement on back of Part 3

Form Approved:
OMB No. 3206-0230

1 General Instructions

By law, unless you waive all coverage or are ineligible, you are automatically covered for Basic life insurance as an employee. When you first become eligible for FEGLI, you may (1) elect Basic and any or all of the options, (2) elect Basic but waive all of the options, or (3) waive all life insurance coverage. If you are changing a previous election, see the back of Part 3 - Employee Copy.

- Read the back of Part 3 - Employee Copy carefully.
- Assignees completing this form should read Items 5 and 6 on the back of Part 3.
- Do not separate the parts. Give this form to your employing office which will complete the form and return your copy to you.

This election supersedes all previous elections.

2 Fill in identifying information concerning the employee.

Name *(Last)*	*(First)*	*(Middle)*	Date of birth *(mm/dd/yyyy)*	Social Security Number

Employing department or agency	OWCP claim number, if applicable	Location of department or agency where employee works *(City, state, ZIP Code)*	Daytime telephone number *(including area code)*

3 **To elect or retain Basic,** sign and date below. If you do not sign for Basic, you may not elect or retain any form of optional insurance. If you do not want any insurance at all, skip to Section 5.

Basic

I want Basic. I authorize deductions to pay my share of the cost. (Basic may be provided without cost to Postal Service employees.)

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →

Date *(mm/dd/yyyy)*

4 **Optional**

If you signed for Basic in item 3 above, you may elect or retain any or all of the following options (UNLESS you have previously waived any or all of these options, in which case you may elect only those options which you are eligible to elect as outlined in the FEGLI booklet). Sign the box(es) below for any option(s) you are eligible for and wish to elect or retain. If you do not sign for an option, you have waived it and your future opportunities to enroll in it are strictly limited. **You will not be covered for any option(s) for which you do not sign below, regardless of whether you previously elected the option(s).**

Option A - Standard	Option B - Additional	Option C - Family
I want Option A. I authorize deductions to pay the full cost.	I want Option B in the multiple of my annual basic pay I indicate below. I authorize deductions to pay the full cost. ☐ 1 times my pay ☐ 2 times my pay ☐ 3 times my pay ☐ 4 times my pay ☐ 5 times my pay	I want Option C in the multiple I indicate below. I understand that **each** multiple is worth $5,000 upon the death of my spouse, and $2,500 upon the death of an eligible child. I authorize deductions to pay the full cost. ☐ 1 multiple ☐ 2 multiples ☐ 3 multiples ☐ 4 multiples ☐ 5 multiples
Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →	**Signature** *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →	**Signature** *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →
Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*

5 **If you want NO life insurance coverage,** sign and date below.

Waiver of all life insurance coverage

I want no life insurance coverage. I understand that any life insurance I have will stop at the end of the last day of the pay period in which my employing office receives this waiver. Further, I cannot get Basic life insurance unless (1) I wait at least 1 year after I sign this form **and** submit satisfactory results of a physical, or (2) I have a break in Federal service of at least 180 days, or (3) I participate in an open enrollment period, which is held infrequently. I understand that I cannot get any optional insurance unless I first have Basic. I understand that my decision to waive life insurance coverage now may affect my eligibility for coverage as a retiree.

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →

Date *(mm/dd/yyyy)*

6 **Agency Use** **Remarks:**

Number of event permitting change *(See back of Part 2)*

Name and address of employing office	Date received in employing office *(mm/dd/yyyy)*	Effective date of coverage *(mm/dd/yyyy)*
	I followed the instructions on the back of Part 1.	
	Signature of authorized agency official	

The employee's copy of this form, when completed by the employing office, together with the FEGLI booklet (RI 76-21 or RI 76-20 for Postal Service employees) constitute the employee's Certificate of Insurance.

PART 1 - File in Official Personnel Folder

Instructions for Agencies

1. Who Should File This Form

- New employees eligible for life insurance.
- Employees appointed to positions that allow life insurance coverage following service in positions that did not allow life insurance coverage.
- Employees who want to change their insurance.
- Reinstated employees who filed a previous waiver of any type of life insurance and who were separated from service for at least 180 days.

Give a new employee a copy of the FEGLI booklet (RI 76-21 or RI 76-20 for Postal Service employees), when he or she reports for duty and ask the employee to return the completed SF 2817 as soon as possible (preferably before the end of the first pay period), but no later than 31 days after his or her appointment.

Employees with prior service in nonexcluded positions who were separated after March 31, 1981, will have an SF 2817 on file in their personnel folders, and that election or waiver of coverage may still be in effect. Do not accept a new SF 2817 unless the employee has a break in Federal service of at least 180 days or is eligible to cancel a previous waiver that has been in effect for at least one year or wishes to reduce coverage.

Until you verify an employee's SF 2817 on file, make deductions based on his or her statement about earlier insurance coverage in the employee's *Declaration for Federal Employment*, OF 306, if completed.

An employee may at any time file an SF 2817 to waive or reduce coverage, **unless** the employee has assigned his/her insurance coverage. If the employee has assigned the insurance, **only** the assignee(s) may waive or reduce the coverage (except for Option C which cannot be assigned).

An employee may elect or increase Basic, Option A, or Option B insurance (but **not** Option C), if a signed waiver has been in effect for more than one year, by submitting a *Request for Insurance*, SF 2822. If approved, ask the employee to submit an SF 2817 showing his or her election. More details are contained on the SF 2822.

An employee who is already enrolled in Basic may elect Option B and/or Option C within 60 days following marriage, divorce, spouse's death, or the acquisition of an eligible child. **Exception:** Acquiring a foster child does not count as a life event for Option B purposes.

- For Option B, the number of multiples he or she may elect (up to 5 total) is limited to the following: (a) for marriage or acquisition of a child, the number of additional family members; (b) for divorce or death of spouse, the total number of the employee's dependent children.
- For Option C, he or she may elect from 1 to 5 multiples (up to 5 total) no matter how many family members he/she has or acquires with the event.

An employee who is already enrolled in Option B and/or Option C for at least one multiple may change to a higher multiple within 60 days following marriage, divorce, spouse's death, or the acquisition of an eligible child. The number of multiples is limited as listed above.

2. Review of Completed Form

Review the original and both copies of the SF 2817 to see that they are legible and complete. If an employee signs the box for Option A, Option B, or Option C, he or she must also sign item 3, Basic.

Only the employee may sign this form in items 3, 4, or 5, with one exception (noted below). Signatures by guardians, conservators, or through a power of attorney are not acceptable.

Exception: If the employee assigned his or her insurance, only the assignee(s) may ***waive*** some or all of the employee's coverage. In that case, the assignee(s) must sign the form (although the information in Section 2 must refer to the employee). Please note that assignees cannot ***increase*** the employee's coverage. Only the employee can do that.

Instruct the employee that, while the agency will make sure that the SF 2817 is complete, he or she is solely responsible for ensuring that the SF 2817 accurately reflects his or her intentions.

3. Completion of Form

The Personnel Officer or his or her designated representative must confirm that the employee is eligible for the coverage that he or she has elected and sign the form in item 6.

4. Date Received

Enter the date the employing office received this form.

5. Number of Event Permitting Change

Enter the number of the event permitting a change, if applicable. See the Table of Effective Dates on the back of Part 2 for event numbers.

6. Effective Date of Coverage

Enter the effective date of coverage. For new and newly eligible employees: Basic is effective on the first day the employee is at work in a pay status; Optional coverage is effective on the first day the employee is at work in a pay status on or after the day the employing office receives the SF 2817. For changes in elections, see the Table of Effective Dates on the back of Part 2. If the employee elected more than one type of coverage and there is more than one effective date, write in both dates and provide details in the Remarks section.

7. Disposition of SF 2817

After completion, remove Part 3 and return it to the employee. File Part 1 in the employee's personnel folder. Destroy Part 2 after payroll office use.

8. Further Information

For further information, consult the FEGLI Handbook (RI 76-26) or the FEGLI Booklet (RI 76-21 or RI 76-20 for Postal Service employees), which are available on the FEGLI web site at www.opm.gov/insure/life.

FEGLI
Federal Employees Group Life Insurance

Life Insurance Election
Federal Employees' Group Life Insurance Program

Form Approved:
OMB No. 3206-0230

1 SF 50 Equivalents of Insurance Codes

INSURANCE	SF 50																		
INELIGIBLE	A0	1005	E5	1011	I1	1114	J4	1025	M5	1031	Q1	1134	R4	1045	U5	1051	Y1	1154	Z4
0000	B0	1101	F1	1012	I2	1115	J5	1121	N1	1032	Q2	1135	R5	1141	V1	1052	Y2	1155	Z5
1000	C0	1102	F2	1013	I3	1020	K0	1122	N2	1033	Q3	1040	S0	1142	V2	1053	Y3		
1100	D0	1103	F3	1014	I4	1120	L0	1123	N3	1034	Q4	1140	T0	1143	V3	1054	Y4		
1001	E1	1104	F4	1015	I5	1021	M1	1124	N4	1035	Q5	1041	U1	1144	V4	1055	Y5		
1002	E2	1105	F5	1111	J1	1022	M2	1125	N5	1131	R1	1042	U2	1145	V5	1151	Z1		
1003	E3	1010	G0	1112	J2	1023	M3	1030	90	1132	R2	1043	U3	1050	W0	1152	Z2		
1004	E4	1110	H0	1113	J3	1024	M4	1130	P0			1044	U4	1150	X0	1153	Z3		

2 Fill in identifying information concerning the employee.

Name *(Last)*	*(First)*	*(Middle)*	Date of birth *(mm/dd/yyyy)*	Social Security Number

Employing department or agency	OWCP claim number, if applicable	Location of department or agency where employee works *(City, state, ZIP Code)*	Daytime telephone number *(including area code)*

3 Basic

In item 7: If this block is not signed, enter **0** in **ALL FOUR** boxes.
If this block is signed, enter **1** in box **1**.

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →

Date *(mm/dd/yyyy)*

4

Option A - Standard	Option B - Additional	Option C - Family
In item 7, box 2: If this block is not signed, enter **0** If this block is signed, enter **1**	In item 7, box 3: If this block is not signed, enter **0** If this block is signed, enter the number marked "X" below ☐ 1 times my pay ☐ 2 times my pay ☐ 3 times my pay ☐ 4 times my pay ☐ 5 times my pay	In item 7, box 4: If this block is not signed, enter **0** If this block is signed, enter the number marked "X" below ☐ 1 multiple ☐ 2 multiples ☐ 3 multiples ☐ 4 multiples ☐ 5 multiples
Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →	**Signature** *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →	**Signature** *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →
Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*

5 If you want NO life insurance coverage at all, sign and date below.

Waiver of all life insurance coverage

In item 7: If this block is signed, enter **0** in **ALL FOUR** boxes.

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →

Date *(mm/dd/yyyy)*

6 Agency Use Remarks:

Number of event permitting change *(See back of Part 2)*

Name and address of employing office	Date received in employing office *(mm/dd/yyyy)*	Effective date of coverage *(mm/dd/yyyy)*

I followed the instructions on the back of Part 1.

Signature of authorized agency official

7 INSTRUCTIONS: Enter codes in the boxes on the right as directed in items 3, 4 and 5 above.

Insurance Code: 1 2 3 4 ☐☐☐☐

SF 50 Equivalent ☐☐

PART 2 - For Agency Use

Table of Effective Dates: Changes in Life Insurance Election

Deductions: Begin, increase, stop or decrease with the pay period in which coverage begins, increases, stops or decreases.

Event Allowing Change	Change Permitted? *(To enroll in any option, employee must enroll or be enrolled in Basic)*			
	Basic	**Option A - Standard**	**Option B - Additional**	**Option C - Family**
1. Physical: Approval of Request for Insurance (SF 2822) by the Office of Federal Employees' Group Life Insurance (OFEGLI).	**Yes. Coverage** is effective on the first day the employee is at work in a pay status after date of OFEGLI's approval. **Time Limit** - OFEGLI's approval expires after 31 days. If employee is not at work in a pay status within those 31 days, Basic does **not** become effective. Employee must obtain a new physical.	**Yes. Coverage** is effective on the first day the employee is at work in a pay status on or after date of OFEGLI's approval **and** agency receives the SF 2817. **Time Limit** - Employee must submit SF 2817 and be at work in a pay status within 31 days after date of OFEGLI's approval. If employee is not at work in a pay status or doesn't submit the SF 2817 within those 31 days, Option A does **not** become effective. Employee must obtain a new physical.	Same as Option A.	No change permitted for this event.
2. Life Event: Marriage, divorce, death of spouse or acquisition of an eligible child.	No change permitted for this event.	No change permitted for this event.	**Yes**. Employee may elect or increase multiples (limited to 5 total) up to (a) for marriage or children, the number of additional family members; (b) for divorce or death of spouse, the total number of dependent children. **Exception:** Acquiring a foster child does not count as a life event for Option B purposes. **Coverage** is effective the day of the event (**IF** employee is at work in a pay status on that day), if employee submits the SF 2817 **before** the event. **Coverage** is effective the first day the employee is at work in a pay status on or after the date of the event, if employee submits the SF 2817 within 60 days **after** the event (or is not at work in a pay status on the day of the event). **Time Limit** - Agency must receive SF 2817 and proof of the event within 60 days after date of event. (Time limit may be extended if event occurs when employee was separated from Federal service or if it occurs 60 days or less before separation.)	Yes. Employee may elect or increase multiples (limited to 5 total) no matter how many family members he/she has or acquires with the event. **Coverage** is effective the day of the event, if employee submits the SF 2817 **before** the event. **Coverage** is effective the day the agency receives the SF 2817, if employee submits it within 60 days **after** the event. **Time Limit** - Agency must receive SF 2817 and proof of the event within 60 days after date of event. (Time limit may be extended if event occurs when employee was separated from Federal service, 60 days or less before separation, or during the year following waiver of Basic.)
3. Employee is reinstated after a break in service of at least 180 days in a position that is not excluded from life insurance by law or regulation.	**Yes. Coverage** is effective on the first day the employee is at work in a pay status, if no new waiver is filed.	**Yes.** Employee may elect any or all optional insurance within 31 days after reinstatement. **Coverage** is the same as with new employees. However, if employee does not submit SF 2817 electing such coverage to his/her agency within 31 days after reinstatement, he/she has the same Optional insurance carried immediately before his/her break in service.	Same as Option A.	Same as Option A.
4. Employee returns to Federal Service after a break in service of at least 180 days in a position that is excluded from life insurance by law or regulation.	**No.** However, if employee is later converted to a non-excluded position, the coverage is effective on the first day the employee is at work in a pay status on or after being converted to such a position.	**No.** However, if employee is later converted to a non-excluded position, the coverage is effective on the first day the employee is converted to such a position wherein he or she is at work in a pay status on or after the date the agency receives the SF 2817 electing such coverage. **Time Limit** - Employee must submit SF 2817 electing such coverage to his or her agency within 31 days after conversion.	Same as Option A.	Same as Option A.
5A. Employee initially waives or subsequently cancels life insurance coverage.	A. **Yes. Coverage** stops at the end of the last day of the pay period in which the agency receives the SF 2817, with **no** 31-day extension of coverage. **Time Limit** - None. Employee may cancel coverage at any time. However, if the insurance is assigned, only the assignee(s) may cancel coverage – the employee may not.	A. Same as Basic.	A. Same as Basic.	A. Same as Basic, except information on assignment is not applicable.
or				
5B. Employee (or if applicable, assignee(s)) elects to decrease optional coverage.	B. Not applicable.	B. Not applicable.	B. **Yes**. Employee may at any time reduce the number of multiples, unless the insurance has been assigned. In that case, only the assignee(s) may reduce coverage – the employee may not. **Coverage** reduces effective on the last day of the pay period in which the agency receives the SF 2817.	B. **Yes**. Employee may at any time reduce the number of multiples. **Coverage** reduces effective on the last day of the pay period in which the agency receives the SF 2817.
6. Open Enrollment Period.	If permitted under conditions specified by OPM.	Same as Basic.	Same as Basic.	Same as Basic.

FEGLI
Federal Employees Group Life Insurance

Life Insurance Election

Federal Employees' Group Life Insurance Program

See Privacy Act Statement on back of Part 3

Form Approved:
OMB No. 3206-0230

1 General Instructions

By law, unless you waive all coverage or are ineligible, you are automatically covered for Basic life insurance as an employee. When you first become eligible for FEGLI, you may (1) elect Basic and any or all of the options, (2) elect Basic but waive all of the options, or (3) waive all life insurance coverage. If you are changing a previous election, see the back of Part 3 - Employee Copy.

- Read the back of Part 3 - Employee Copy carefully.
- Assignees completing this form should read Items 5 and 6 on the back of Part 3.
- Do not separate the parts. Give this form to your employing office which will complete the form and return your copy to you.

This election supersedes all previous elections.

2 Fill in identifying information concerning the employee.

Name *(Last)*	*(First)*	*(Middle)*	Date of birth *(mm/dd/yyyy)*	Social Security Number

Employing department or agency	OWCP claim number, if applicable	Location of department or agency where employee works *(City, state, ZIP Code)*	Daytime telephone number *(including area code)*

3 To elect or retain Basic, sign and date below. If you do not sign for Basic, you may not elect or retain any form of optional insurance. If you do not want any insurance at all, skip to Section 5.

Basic

I want Basic. I authorize deductions to pay my share of the cost. (Basic may be provided without cost to Postal Service employees.)

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →

Date *(mm/dd/yyyy)*

4 Optional

If you signed for Basic in item 3 above, you may elect or retain any or all of the following options (UNLESS you have previously waived any or all of these options, in which case you may elect only those options which you are eligible to elect as outlined in the FEGLI booklet). Sign the box(es) below for any option(s) you are eligible for and wish to elect or retain. If you do not sign for an option, you have waived it and your future opportunities to enroll in it are strictly limited. **You will not be covered for any option(s) for which you do not sign below, regardless of whether you previously elected the option(s).**

Option A - Standard

I want Option A.
I authorize deductions to pay the full cost.

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →

Date *(mm/dd/yyyy)*

Option B - Additional

I want Option B in the multiple of my annual basic pay I indicate below. I authorize deductions to pay the full cost.

☐ 1 times my pay
☐ 2 times my pay
☐ 3 times my pay
☐ 4 times my pay
☐ 5 times my pay

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →

Date *(mm/dd/yyyy)*

Option C - Family

I want Option C in the multiple I indicate below. I understand that **each** multiple is worth $5,000 upon the death of my spouse, and $2,500 upon the death of an eligible child. I authorize deductions to pay the full cost.

☐ 1 multiple
☐ 2 multiples
☐ 3 multiples
☐ 4 multiples
☐ 5 multiples

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →

Date *(mm/dd/yyyy)*

5 If you want NO life insurance coverage, sign and date below.

Waiver of all life insurance coverage

I want no life insurance coverage. I understand that any life insurance I have will stop at the end of the last day of the pay period in which my employing office receives this waiver. Further, I cannot get Basic life insurance unless (1) I wait at least 1 year after I sign this form **and** submit satisfactory results of a physical, or (2) I have a break in Federal service of at least 180 days, or (3) I participate in an open enrollment period, which is held infrequently. I understand that I cannot get any optional insurance unless I first have Basic. I understand that my decision to waive life insurance coverage now may affect my eligibility for coverage as a retiree.

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →

Date *(mm/dd/yyyy)*

6 Agency Use Remarks:

Number of event permitting change *(See back of Part 2)*

Name and address of employing office	Date received in employing office *(mm/dd/yyyy)*	Effective date of coverage *(mm/dd/yyyy)*
	I followed the instructions on the back of Part 1.	
	Signature of authorized agency official	

The employee's copy of this form, when completed by the employing office, together with the FEGLI booklet (RI 76-21 or RI 76-20 for Postal Service employees) constitute the employee's Certificate of Insurance.

PART 3 - Employee Copy

Instructions for Employees

1. General Information

The major provisions of this program are described in the *Federal Employees' Group Life Insurance (FEGLI)* booklet (RI 76-21 or RI 76-20 for Postal Service employees, available from your employing office). Please read the entire booklet carefully. Your completed copy of this election form and the FEGLI booklet constitute your certification of coverage.

2. New Employees and Employees Newly Eligible for Life Insurance

You are automatically enrolled in Basic unless you waive it. If you waive Basic, you automatically waive all forms of Optional insurance. You will not have any Optional insurance unless you elect it.

To elect Basic: You do not need to submit this form unless you also wish to elect Optional insurance. If you do not submit this form, you will have Basic, but no Optional coverage.

To waive Basic: Sign Section 5 of the form and give it to your employing office. Your agency will withhold Basic premiums from your salary from your first day at work in a pay status UNLESS you submit your waiver before the end of your first pay period.

To elect Optional: Sign Section 3 and one or more of the blocks in Section 4 of the form and give it to your employing office within 31 days after the date you are appointed or first become eligible for life insurance.

To waive Optional: If you do not sign for a particular type of Optional coverage in Section 4, you automatically waive that coverage. If you do not submit the form at all, you will have Basic, but no Optional coverage.

3. Employees With Prior Government Service

A life insurance election or waiver on SF 2817 filed during a prior period of Federal employment stays in effect unless you change coverage or have a break in service of at least 180 days.

A break in service of at least 180 days cancels any previous waiver of insurance. Unless you file a new waiver, Basic becomes effective on the first day you actually enter on duty in a pay status in a position in which you are eligible for coverage. You can elect any amount of Optional insurance within 31 days of returning to service, regardless of the coverage you had during previous employment. If you fail to elect any Optional insurance, you will automatically get the Optional insurance you carried immediately before your break in service.

If you had a break in service of less than 180 days and were eligible in your last period of Federal employment, your life insurance in your new employment will be the same as you had then and if you waived coverage then, the waiver is still in effect. Your opportunities to cancel your waiver are strictly limited. See the FEGLI booklet.

4. Reemployed Annuitants

If you waive your insurance as a reemployed annuitant, you also waive your insurance as an annuitant, and you will have no Federal life insurance.

5. Assignment

If you have assigned your insurance by filing an RI 76-10, *Assignment of Federal Employees' Group Life Insurance*, you may not cancel any of your current insurance coverage. Only the assignee(s) may cancel your coverage. However, you may elect new coverage if you otherwise meet the requirements for electing such coverage. Any new coverage you elect will automatically be subject to your existing assignment, except for Option C, which you cannot assign. All assignments are automatically canceled after a break in service of at least 31 days, or upon cancellation of all life insurance coverage by the assignee(s).

6. Attention Assignees

If you are completing this form in order to cancel some or all of the employee's life insurance coverage, you must sign the form. The information in Section 2 of the form refers to the employee, but you must sign in Section 3, 4 or 5, as applicable. Indicate "assignee" after your signature. Return the completed form to the employee's employing office. If the insured is an annuitant, return the completed form to OPM, Retirement Operations Center, P.O. Box 45, Boyers, PA 16017-0045. See #11 for where to return the completed form if the insured is a compensationer.

7. How to Complete and Review Your Election Form

Follow the instructions for each item carefully. After you fill out the form, review it to be sure it is complete and correct. The following checklist should help.

If you sign item 3, you elect (or retain) **Basic**. Do not also sign item 5. (You cannot elect (or retain) **and** waive coverage.)

If you sign any block in item 4, you must also sign item 3. (To elect (or retain) an option, you must also elect (or retain) Basic.)

If you sign item 4 for Option B and/or Option C, you must also mark one of the five boxes to show how many multiples you wish to elect (or retain). Do not mark more than one.

Be sure you sign for all options you want. This election supersedes all previous ones. If you have optional coverage and wish to keep it, you must sign the appropriate box(es). If you do not sign for it, you have waived it.

If you sign item 5, you waive Basic. Do not sign item 3 or any block in item 4. (You cannot waive **and** elect coverage.)

Only you, the employee, may sign this form. Signatures by guardians, conservators, or through a power of attorney are not acceptable. **Exception:** If you have assigned your insurance, only the assignee(s) may cancel some or all of your coverage. In that case, the assignee(s) must sign the form (although the information in Section 2 must refer to you).

REMEMBER THAT YOU, NOT YOUR AGENCY, ARE RESPONSIBLE FOR ENSURING THAT YOUR SF 2817 IS CORRECT AND ACCURATELY REFLECTS YOUR INTENTIONS.

8. 1999 Open Enrollment Period

If you elected coverage during the 1999 Open Enrollment Period, and that coverage has not yet become effective, and you want to make a further change to your FEGLI coverage on this SF 2817, you should check with your employing office. That office can tell you about any special election procedures that may apply.

9. Waiving or Changing Your Insurance Coverage

If you do not sign for a particular type of coverage, you have waived that coverage. If you waive Basic or one or more of the options, your opportunities to enroll in the coverage you waived are strictly limited. A waiver may also affect your eligibility to continue coverage into retirement. See the FEGLI booklet.

10. Where to Send Completed Form

After you have completed this form and verified that it accurately reflects your intentions, send the entire form (without separating the parts) to your employing office.

11. Compensationers

If you are receiving compensation payments from the Office of Workers' Compensation Programs (OWCP), provide your OWCP number in Section 2 of the form. If you are still employed, return the completed form to your employing office. If you are not still employed or if you have been receiving compensation payments for at least 12 months, return the completed form to OPM, Retirement Operations Center, P.O. Box 45, Boyers, PA 16017-0045.

12. How to Verify that Your Agency Processed Your Election

After your employing office processes your election form, you will receive an SF 50, *Notice of Personnel Action*. A two digit code appearing on the SF 50 will explain your insurance coverage. These codes are explained on Part 2 of the SF 2817. Also check your pay statement for the correct withholdings. If you are insured as a compensationer, you will receive a notice from OPM which will explain your insurance coverage.

13. Further Information

For further information, consult the *FEGLI Handbook* (RI 76-26) or the *FEGLI Booklet* (RI 76-21 or RI 76-20 for Postal Service employees), which are available on the FEGLI web site at www.opm.gov/insure/life.

Privacy Act and Public Burden Statements

Chapter 87, title 5, U.S. Code, Federal Employees' Group Life Insurance, authorizes solicitation of this information. The data you furnish will be used to determine your life insurance coverage. This information may be shared and is subject to verification, via paper, electronic media, or through the use of the computer matching programs, with national, state, local or other charitable or social security administrative agencies to determine and issue benefits under their programs or law enforcement agencies, when they are investigating a violation or potential violation of the civil or criminal law. Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal government furnish a Social Security Number or tax identification number. This is an amendment to title 31, Section 7701. Failure to furnish the requested information may result in OPM's inability to determine your life insurance coverage.

We think this form takes an average of 15 minutes to complete including the time for getting the needed data and reviewing both the instructions and completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management (OPM), Reports and Forms Manager, Paperwork Reduction Project (3206-0230), Washington, DC 20415-7900. The OMB Number, 3206-0230 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Federal Employees Group Life Insurance

Designation of Beneficiary
Federal Employees' Group Life Insurance (FEGLI) Program
(DO NOT erase or cross-out. Use a new form.)

Form Approved
OMB No. 3206-0136

Important:
Read instructions on the Back of Part 2 before completing this form.

A. Information About the Insured (not the Assignee, if there is one) (type or print)

Name of Insured *(Last, first, middle)*	Date of birth of Insured *(mm/dd/yyyy)*	Social Security Number of Insured

The Insured is:
Place an "X" in the appropriate box.

- ☐ an employee
- ☐ a retiree
- ☐ a compensationer

If the Insured is retired or receiving Federal Employees' Compensation, give CSA, CSI, or OWCP claim number:

Department or agency where the Insured works *(If retired, last department or agency where the Insured worked):*

Department or agency	Bureau or division	Location *(city, state, and ZIP code)*

B. Information About the Beneficiary or Beneficiaries (See Back of Part 1 for examples) (type or print)

[illegible]	Social Security Number	[illegible]	[illegible]	[illegible]
				0%
				0%
				0%
				0%
				0%
				0%

Total (Must equal 100% or 1.0) (Do not use dollar amounts) → 0%

(Do not put a Total if you designated types of insurance. See example 4 on Back of Part 1.)

C. Statement of Insured or Assignee (type or print)

Your name and address *(Including ZIP code)*

Please check one:
I am:

- ☐ the Insured
- ☐ an Assignee

See Back of Part 2 for definitions

Please check all three:

- ☐ I have not assigned the insurance.
- ☐ Two people who witnessed my signature signed below.
- ☐ I did not name either witness as a beneficiary.

I understand that if there is a valid assignment on file, only the assignee has the right to designate a beneficiary. If a valid assignment is not on file, but there is a valid court order on file with the agency or the U.S. Office of Personnel Management, as appropriate, any designation I complete for the same benefits is not valid.

I understand that if this Designation is valid, it will stay in effect unless it is canceled. (See "When Is A Designation Canceled?" on the Back of Part 2).

I understand that if this Designation is invalid for any reason, the Office of Federal Employees' Group Life Insurance will pay benefits according to the next most recent valid designation. If there isn't one, it will pay according to the order listed on the Back of Part 2.

I am canceling any and all previous Designations of Beneficiary under the Federal Employees' Group Life Insurance Program and am now designating the beneficiary(ies) named above.

Signature of Insured/Assignee *(Only the Insured/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* This form is not valid unless the Insured/Assignee signs in this box.	Date *(mm/dd/yyyy)*

D. Witnesses To Signature (A witness is not eligible to receive a payment as a beneficiary.)

Signature of witness	Address *(Including ZIP code)*
Signature of witness	Address *(Including ZIP code)*

E. For Agency Use Only

Receiving agency	Date of receipt *(mm/dd/yyyy)*	Signature of authorized agency official	Title

Examples of Designations

1. How to designate one beneficiary Show beneficiary's full name. Do not write names as M.E. Brown or as Mrs. John H. Brown. If you want to designate your estate, enter "My estate" in the beneficiary column.

First name, middle initial, and last name of each beneficiary	Social Security Number	Address *(Including ZIP code)*	Relationship	Percent or fraction designated
Mary E. Brown	000-00-0000	214 Central Avenue Munice, IN 47303	Niece	100%

2. How to designate more than one beneficiary Be sure that the shares to be paid to the several beneficiaries add up to 100 percent or 1.0. Read instructions on the Back of Part 2 if you need more room.

First name, middle initial, and last name of each beneficiary	Social Security Number	Address *(Including ZIP code)*	Relationship	Percent or fraction designated
Jose P. Lopez	111-11-1111	360 Williams Street Red Band, NJ 07701	Nephew	one-half
Rosa L. Rowe	222-22-2222	792 Broadway Whiting, IN 46392	Mother	one-half

3. How to designate a contingent beneficiary ***(Someone to receive the benefits if the person you designate dies before the Insured dies)***

First name, middle initial, and last name of each beneficiary	Social Security Number	Address *(Including ZIP code)*	Relationship	Percent or fraction designated
John M. Parrish, if living	333-33-3333	810 West 180th Street New York, NY 10033	Father	100%
Otherwise to: Susan A. Parrish	444-44-4444	810 West 180th Street New York, NY 10033	Sister	100%

4. How to designate different beneficiaries for Basic and Optional insurance You cannot designate Option C - Family.

First name, middle initial, and last name of each beneficiary	Social Security Number	Address *(Including ZIP code)*	Relationship	Percent or fraction designated
Leroy D. White	555-55-5555	124 Elm Street Dayton, OH 45420	Father	100% Basic
Jane M. Smith	666-66-6666	421 Spring Avenue Portland, ME 04101	Sister	100% Option A
Elizabeth J. Allen	777-77-7777	234 Fifth Avenue New York, NY 10029	Daughter	50% Option B
Ann J. Borden	888-88-8888	678 Ninth Street Philadelphia, PA 19123	Daughter	50% Option B

5. How to designate an inter vivos trust ***(A trust that you set up during your lifetime)***

First name, middle initial, and last name of each beneficiary	Social Security Number	Address *(Including ZIP code)*	Relationship	Percent or fraction designated
Trustee(s) or Successor Trustee(s) as provided in the John Q. Public Trust Agreement dated 12/18/1999, if valid. Otherwise to:			Trustee	100%
Mary E. Brown	000-00-0000	214 Central Avenue Munice, IN 47303	Niece	100%

6. How to designate a testamentary trust ***(A trust that is set up when you die, according to terms in your will)***

First name, middle initial, and last name of each beneficiary	Social Security Number	Address *(Including ZIP code)*	Relationship	Percent or fraction designated
Trustee(s) or Successor Trustee(s) as provided in my Last Will and Testament, if valid. Otherwise to:			Trustee	100%
Maria Sufuentes	999-99-9999	5909 Pacific Avenue, NW Washington, DC 20019	Niece	100%

7. How to cancel all designations of beneficiary

First name, middle initial, and last name of each beneficiary	Social Security Number	Address *(Including ZIP code)*	Relationship	Percent or fraction designated
Cancel prior designations				

Federal Employees Group Life Insurance

Designation of Beneficiary
Federal Employees' Group Life Insurance (FEGLI) Program
(DO NOT erase or cross-out. Use a new form.)

Form Approved
OMB No. 3206-0136

Important:
Read instructions on the Back of Part 2 before completing this form.

A. Information About the Insured (not the Assignee, if there is one) (type or print)

Name of Insured *(Last, first, middle)*	Date of birth of Insured *(mm/dd/yyyy)*	Social Security Number of Insured

The Insured is: *Place an "X" in the appropriate box.*
- ☐ an employee
- ☐ a retiree
- ☐ a compensationer

If the Insured is retired or receiving Federal Employees' Compensation, give CSA, CSI, or OWCP claim number:

Department or agency where the Insured works *(If retired, last department or agency where the Insured worked):*

Department or agency	Bureau or division	Location *(City, state, and ZIP code)*

B. Information About the Beneficiary or Beneficiaries (See Back of Part 1 for examples) (type or print)

Name (First, middle initial, last) of each beneficiary	Social Security Number	Address *(Including ZIP code)*	Relationship	Percent to be designated
				0%
				0%
				0%
				0%
				0%
				0%

Total (Must equal 100% or 1.0) (Do not use dollar amounts) → 0%
(Do not put a Total if you designated types of insurance. See example 4 on Back of Part 1.)

C. Statement of Insured or Assignee (type or print)

Your name and address *(Including ZIP code)*

Please check one:
I am:
- ☐ the Insured
- ☐ an Assignee

See Back of Part 2 for definitions

Please check all three:
- ☐ I have not assigned the insurance.
- ☐ Two people who witnessed my signature signed below.
- ☐ I did not name either witness as a beneficiary.

I understand that if there is a valid assignment on file, only the assignee has the right to designate a beneficiary. If a valid assignment is not on file, but there is a valid court order on file with the agency or the U.S. Office of Personnel Management, as appropriate, any designation I complete for the same benefits is not valid.

I understand that if this Designation is valid, it will stay in effect unless it is canceled. (See "When Is A Designation Canceled?" on the Back of Part 2).

I understand that if this Designation is invalid for any reason, the Office of Federal Employees' Group Life Insurance will pay benefits according to the next most recent valid designation. If there isn't one, it will pay according to the order listed on the Back of Part 2.

I am canceling any and all previous Designations of Beneficiary under the Federal Employees' Group Life Insurance Program and am now designating the beneficiary(ies) named above.

Signature of Insured/Assignee *(Only the Insured/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* This form is not valid unless the Insured/Assignee signs in this box.	Date *(mm/dd/yyyy)*

D. Witnesses To Signature (A witness is not eligible to receive a payment as a beneficiary.)

Signature of witness	Address *(Including ZIP code)*
Signature of witness	Address *(Including ZIP code)*

E. For Agency Use Only

Receiving agency	Date of receipt *(mm/dd/yyyy)*	Signature of authorized agency official	Title

Part 2 - Duplicate

INSTRUCTIONS: The Insured or assignee must sign this form. Two people must witness the signature and sign as witnesses. The Insured's agency (or U.S. Office of Personnel Management [OPM], if the Insured is an annuitant or insured as a compensationer) must receive the designation before the Insured's death. A person with a power of attorney or other similar legal authority may not sign for the Insured or assignee. A witness cannot be a beneficiary. The agency or OPM, as appropriate, must receive certified court orders involving FEGLI on or after July 22, 1998, and before the Insured's death.

Please read the additional instructions below before completing this form.

"You" and "your" refer to the person completing this form (the Insured or an assignee). The "Insured" is the insured employee, annuitant or compensationer. The "Assignee" is a person(s), firm(s), or trust(s) (usually named on an Assignment form, RI 76-10) who owns and controls the Insured's life insurance coverage. An assignment is not the same as a designation of beneficiary.

Who receives benefits when the Insured dies? By law, the Office of Federal Employees' Group Life Insurance (OFEGLI) pays benefits in this order:

- If the Insured assigned ownership of his/her insurance (usually by filing an RI 76-10, *Assignment of Life Insurance*), OFEGLI will pay:
  First, to the beneficiary(ies) the assignee(s) validly designated;
  Second, if none, to the assignee(s).
- If the Insured did not assign ownership and there is a valid court order (see 5 Code of Federal Regulations Part 870) on file with the agency or OPM, as appropriate, OFEGLI will pay benefits according to the court order.
- If the Insured did not assign ownership and there is no valid court order on file with the agency or OPM, as appropriate, then OFEGLI will pay:
  First, to the beneficiary(ies) the Insured validly designated;
  Second, if none, to the Insured's widow or widower;
  Third, if none of the above, to the Insured's child or children and the descendants of any deceased children (a court will usually have to appoint a guardian to receive payment for a minor child);
  Fourth, if none of the above, to the Insured's parents in equal shares, or the entire amount to the surviving parent;
  Fifth, if none of the above, to the court-appointed executor or administrator of the Insured's estate;
  Sixth, if none of the above, to the Insured's other next of kin entitled under the laws of the State where the Insured lived.

Do I have to designate a beneficiary? No. But if you want OFEGLI to pay differently than listed above and you have not assigned the life insurance and there is no valid court order on file with the agency or OPM, as appropriate, you need to designate a beneficiary.

What if one of the beneficiaries dies or is disqualified for any reason? Unless you indicate otherwise on your designation of beneficiary, OFEGLI will distribute that beneficiary's share equally among the surviving beneficiaries, or entirely to the sole survivor.

What if none of the beneficiaries is living when the Insured dies? OFEGLI will pay the benefits according to the order of precedence listed above.

Can I cancel or change this designation at any time? Yes, you may cancel or change your designation at any time, without the knowledge of or consent of the beneficiary(ies), unless you assigned the insurance or there is a valid court order on file with the agency or OPM, as appropriate.

Is a change or cancellation of beneficiary in my last will or testament valid? It is valid only if you sign your will, two people who witnessed your signature sign your will, and your agency (or OPM, for retirees or insured compensationers) receives your will before the Insured's death.

What if I don't know a beneficiary's social security number? If you don't know the number, leave it blank. But having the number helps speed up the payment of benefits.

Can a witness receive benefits as a designated beneficiary? No.

Who can I name as a beneficiary? You may name any person, firm, corporation or legal entity (except an agency of the Federal or District of Columbia government).

Can I use a common disaster clause? Yes. A common disaster clause is a statement that says that a designated beneficiary is entitled to the benefits only if he/she survives the Insured by a specified minimum number of days. The number of days cannot exceed 30. You can name a contingent beneficiary. If you don't name a contingent and your beneficiary does ***not*** live long enough to qualify, OFEGLI will pay according to the order listed in the first column.

Can I designate a trust? Yes. See examples 5 and 6 on the Back of Part 1. Those examples name a contingent beneficiary in case the trust is not valid. You don't have to name a contingent beneficiary unless you want to. If the trust is not valid, and you do not name a contingent, OFEGLI will pay according to the order listed in the first column.

When is a designation canceled? A designation of beneficiary is automatically canceled 31 days after the Insured stops being insured. It is also canceled if either the Insured or assignee assigns the insurance or if the Insured or assignee submits another valid designation.

What if the Insured elected a full living benefit? Then there is no Basic left. So if you want to designate different types of insurance to different beneficiaries (see example 4 on the Back of Part 1), you should only list Option A and Option B.

Who can sign this form? The Insured or Assignee (if applicable) must sign this form. The signature of a guardian, conservator or other fiduciary (including, but not limited to, those acting according to a Power of Attorney or a Durable Power of Attorney) is ***not*** acceptable.

What if I erase or cross out something on this form? You should complete another form. Erasures, cross-outs and alterations cause a delay in the payment of benefits and may make the entire designation invalid.

What if I need more room? Write "See Attached" in Part B of the form. Use a blank sheet. Print your name, date of birth and social security number at the top of the attachment. List the information required in Part B for each beneficiary. Sign the form and attachment. Have the same two people witness both of your signatures and sign the form and attachment.

Where can I get more information? The FEGLI Handbook (RI 76-26) and FEGLI Booklet (RI 76-21 or RI 76-20 for Postal employees) contain more information. You can read them at *www.opm.gov/insure/life*.

Where should I send this form? Send it to the Insured's employing agency if the Insured:

- is an employee; or
- has been receiving compensation payments from the Office of Workers' Compensation Programs for less than 12 months and is still on the agency's rolls as an employee.

Send it to the Office of Personnel Management, Retirement Operations Center, P.O. Box 45, Boyers, PA 16017-0045 if the Insured:

- is a retiree; or
- is receiving compensation payments from the Office of Workers' Compensation Programs and is not still employed or has been receiving compensation payments for at least 12 months.

The agency or OPM will note receipt in section E of the form and return a copy to you as evidence that it received and filed the original.

Properly completed designations are not valid unless the appropriate office listed above receives them before the Insured's death.

Privacy Act and Public Burden Statements

Title 5, U.S. Code, chapter 87, Life Insurance, authorizes solicitation of this information. The Office of Federal Employees' Group Life Insurance (OFEGLI) will use the information you furnish to determine your beneficiary(ies) for benefits under the Federal Employees' Group Life Insurance Program. OFEGLI is not a Federal agency. It is staffed by employees of the contracted life insurance carrier. It may share this information with the Office of Personnel Management (OPM). Agencies and/or OPM will place this information in the Insured's Official Personnel Folder or retirement file. OPM or OFEGLI may disclose this information to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local or other charitable or social security administrative agencies to determine and issue benefits under their programs. In addition, to the extent this information indicates possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

We also ask for the Insured's Social Security Number to use it as an individual identifier in the Federal Employees' Group Life Insurance Program. Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal government furnish a social security number or tax identification number. This is an amendment to title 31, Section 7701.

While the law does not require you to supply all the information requested on this form, doing so will help in the prompt processing of your designation.

Agencies other than the Office of Personnel Management may have further routine uses for disclosure of information from the records systems in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time you complete this form.

We think this form takes an average of 15 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, Reports and Forms Coordinator, (3206-0136), Washington, D.C. 20415-7900. The OMB number, 3206-0136, is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Keep Your Designation Current. Submit a New One If the Address of One of Your Beneficiaries Changes or If Your Intentions Change
(for example, due to a change in family status, such as marriage, divorce, death, birth, etc.).

FERS
Federal Employees Retirement System

Designation of Beneficiary

Federal Employees' Retirement System

Form Approved
OMB No. 3206-0173

Important
Read all instructions before filling in this form

A. Identification

Name *(Last, first, middle)*	Date of birth *(Month, day, year)*	Social Security Number

Place an "X" in the appropriate box.

☐ An employee	☐ Retired or an applicant for retirement	☐ Former employee eligible for retirement in the future	If you are retired give your claim number

Department or agency in which presently employed *(or former department or agency):*

Department or agency	*Bureau*	*Division*	*Location (City, state and ZIP code)*

I, the individual identified above, designate the beneficiary or beneficiaries named below to receive any lump-sum benefit which may become payable under the Federal Employees' Retirement System (FERS) after my death. I understand that this designation of beneficiary is also for any lump-sum benefit which may become payable under the Civil Service Retirement System (CSRS) after my death. I understand that this designation of beneficiary cancels any previous FERS or CSRS designation of beneficiary, and that it remains in effect until I cancel it in writing or I receive payment of my employee deductions for FERS (and CSRS, if applicable).

I direct, unless otherwise indicated below, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or who may be disqualified for any other reason, shall be distributed equally among the stated beneficiaries, or entirely to the survivor. If none of the beneficiaries are alive and eligible to receive payment when a lump-sum payment becomes payable, this designation is void, and payment will be made according to the order of precedence set by law.

B. Information Concerning The Beneficiaries (See Examples of Designations):

First name, middle initial, and last name of each beneficiary	Address (including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Date of designation *(Mo., day, yr.)*	**Your signature**		**Total = 100%**

C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness	Number and street	City, state and ZIP code
Signature of witness	Number and street	City, state and ZIP code

Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date Received	*Signature*	*Date*

Type or print your return address to insure return of copy

See Back of Employee Copy For Instructions On Where To File This Form. (Retain until employee leaves Federal service and then send to OPM)

PART 1-Original

Important - The filing of this form will completely cancel any Designation of Beneficiary under the Federal Employees' Retirement System or under the Civil Service Retirement System you may have previously filed. Be sure to name in this form all persons you wish to designate as beneficiaries of any lump sum payable at your death.

Examples of Designations

1. HOW TO DESIGNATE ONE BENEFICIARY Do not write names as M.E. Brown or as Mrs. John H. Brown. If you want to designate your estate as beneficiary, enter "My estate" in the beneficiary column.

First name, middle initial, and last name of each beneficiary	Address *(including ZIP code)* of each beneficiary	Relationship	Share to be paid to each beneficiary
Mary E. Brown	214 Central Avenue Muncie, IN 47303	Niece	*100%*

2. HOW TO DESIGNATE MORE THAN ONE BENEFICIARY Be sure that the shares to be paid to the several beneficiaries add up to 100 percent.

First name, middle initial, and last name of each beneficiary	Address *(including ZIP code)* of each beneficiary	Relationship	Share to be paid to each beneficiary
Alice M. Long	509 Canal Street Red Bank, NJ 07701	Aunt	25%
Joseph P. Brady	360 Williams Street Red Bank, NJ 07701	Nephew	25%
Catherine L. Rowe	792 Broadway Whiting, IN 46394	Mother	50%

3. HOW TO DESIGNATE A CONTINGENT BENEFICIARY

First name, middle initial, and last name of each beneficiary	Address *(including ZIP code)* of each beneficiary	Relationship	Share to be paid to each beneficiary
John M. Parrish, if living	810 West 180th Street New York, NY 10033	Father	100%
Otherwise to: Susan A. Parrish	810 West 180th Street New York, NY 10033	Sister	100%

4. HOW TO CANCEL A DESIGNATION OF BENEFICIARY AND EFFECT PAYMENT UNDER ORDER OF PRECEDENCE (See back of duplicate)

First name, middle initial, and last name of each beneficiary	Address *(including ZIP code)* of each beneficiary	Relationship	Share to be paid to each beneficiary
Cancel prior designations			

FERS
Federal Employees Retirement System

Designation of Beneficiary

Federal Employees' Retirement System

Form Approved
OMB No. 3206-0173

Important
Read all instructions before filling in this form

A. Identification

Name *(Last, first, middle)*	Date of birth *(Month, day, year)*	Social Security Number

Place an "X" in the appropriate box.

An employee	Retired or an applicant for retirement	Former employee eligible for retirement in the future	If you are retired give your claim number

Department or agency in which presently employed *(or former department or agency):*

Department or agency	*Bureau*	*Division*	*Location (City, state and ZIP code)*

I, the individual identified above, designate the beneficiary or beneficiaries named below to receive any lump-sum benefit which may become payable under the Federal Employees' Retirement System (FERS) after my death. I understand that this designation of beneficiary is also for any lump-sum benefit which may become payable under the Civil Service Retirement System (CSRS) after my death. I understand that this designation of beneficiary cancels any previous FERS or CSRS designation of beneficiary, and that it remains in effect until I cancel it in writing or I receive payment of my employee deductions for FERS (and CSRS, if applicable).

I direct, unless otherwise indicated below, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or who may be disqualified for any other reason, shall be distributed equally among the stated beneficiaries, or entirely to the survivor. If none of the beneficiaries are alive and eligible to receive payment when a lump-sum payment becomes payable, this designation is void, and payment will be made according to the order of precedence set by law.

B. Information Concerning The Beneficiaries (See Examples of Designations):

First name, middle initial, and last name of each beneficiary	Address (including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Date of designation *(Mo., day, yr.)*	**Your signature**		**Total = 100%**

C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness	Number and street	City, state and ZIP code
Signature of witness	**Number and street**	**City, state and ZIP code**

Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date Received	*Signature*	*Date*

Type or print your return address to insure return of copy

See Back of Employee Copy For Instructions On Where To File This Form.

PART 2-Employee Copy

Instructions

This Designation of Beneficiary Form is used to designate who is to receive a lump-sum payment which may become payable under the Federal Employees' Retirement System (FERS). It does not affect the right of any person who is eligible for survivor annuity benefits. Do not confuse this form with designation forms used for other types of benefits: Standard Form 2808, *Designation of Beneficiary, Civil Service Retirement System,* Standard Form 2823, *Designation of Beneficiary, Federal Employees' Group Life Insurance Program,* TSP-3, *Federal Retirement Thrift Savings Plan Designation of Beneficiarys,* or Standard Form 1152, *Designation of Beneficiary, Unpaid Compensation of Deceased Civilian Employee.*

Do not fill out this form until you have read the information and instructions below

Important - The filing of this form will completely cancel any Designation of Beneficiary under the Federal Employees' Retirement System or under the Civil Service Retirement System you may have previously filed. Be sure to name in this form all persons you wish to designate as beneficiaries of any lump sum payable at your death.

Order of Precedence

You do not need to make a designation if you are satisfied with the order of precedence that the law provides. That order of precedence follows:

1. To your widow or widower.
2. If your widow(er) is deceased, to your child or children, with the share of any deceased child distributed among the descendants of that child.
3. If none of the above, to your parents in equal shares or the entire amount to the surviving parent.
4. If none of the above, to the executor or administrator of your estate.
5. If none of the above, to your other next of kin under the laws of the State in which you live at the time of your death.

Payment of a lump sum will be made to the first person or persons listed above who are alive on the day you die.

Designating a Beneficiary

1. You can designate any person, firm, corporation, or legal entity as your beneficiary.
2. You can change your beneficiary at any time, without the knowledge or consent of a previous beneficiary, and this right cannot be waived or restricted.
3. A designation of beneficiary must be in writing, signed, and witnessed. If you are an employee, the designation must be received in your employing office prior to your death. If you are a separated employee, a retiree or a person receiving recurring payments from the Office of Workers Compensation Programs (OWCP), the designation must be received by the Office of Personnel Management prior to your death.
4. A witness to a designation of beneficiary is ineligible to receive payment as a beneficiary.
5. The person(s) named will be considered a beneficiary (beneficiaries) for **both** CSRS and FERS lump-sum benefits.
6. You cannot change or cancel a designation of beneficiary in a last will or testament unless it is signed, witnessed, and filed as described in paragraph 3.
7. A designation of beneficiary remains in effect until (1) you cancel it by filing a new designation, or (2) you receive a refund of your retirement deductions before retirement. It isn't necessary to file a new designation if the name or address of your beneficiary changes. However, it may be important to file a new designation if your situation changes.

Completing the Designation Form

1. The examples printed on the back of the first page of this form may be helpful to you in naming a beneficiary or canceling a prior designation of beneficiary.
2. If you designate more than one beneficiary, be sure that the shares to be paid to them add up to 100 percent.
3. Complete the form in duplicate. Type or print all entries except signatures.
4. Do not erase or alter entries.

Where to Submit the Completed Form

For employees: File this form with your employing agency, even if you are retiring.

For separated employees, retirees and individuals receiving recurring benefits from the Office of Workers Compensation Programs (OWCP): If you have left Federal employment, if you are receiving recurring benefits from the Office of Workers Compensation Programs, or if you have retired, file this form with the Office of Personnel Management, FERS, P.O. Box 200, Boyers, PA 16017.

Your designation will not be effective until the date it is received by your employing agency (or OPM if you are not employed).

The employee copy of this form will be noted and returned to you as evidence that the original has been received and filed. Please keep the duplicate in a safe place along with your other important papers.

For the employing agency: File the OPF copy on the right side of the OPF. If the employee leaves Federal service, send the most recent designation to OPM.

Privacy Act and Public Burden Statements

Solicitation of this information is authorized by the Civil Service Retirement law (Chapter 83, title 5, U.S. code) and the Federal Employees' Retirement law (Chapter 84, title 5, U.S. code). The information you furnish will be used to determine who will receive a lump sum benefit in the event of your death. The information may be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local or other charitable or social security administrative agencies in order to determine benefits under their programs, to obtain information necessary for determination of benefits under this program, or to report income for tax purposes. It may also be shared and verified, as noted above, with law enforcement agencies when they are investigating a violation or potential violation of the civil or criminal law. Executive Order 9397, (November 22, 1943), authorizes the use of the Social Security Number. Furnishing the Social Security Number, as well as other data, is voluntary, but failure to do so may delay or make it impossible for us to determine how to make payment in the event of your death.

We think providing this information takes an average of 15 minutes per response to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our estimate or any other aspect of SF 3102, including suggestions for reducing completion time, to the Office of Management and Budget, Paperwork Reduction Project, (3206-0173), Washington, D.C. 20503.

Released 6/23/99.

Standard Form 1152
(Rev. 11-91)
Title 4, GAO Manual
1152-108
NSN 7540-00-634-4340

DESIGNATION OF BENEFICIARY

UNPAID COMPENSATION OF DECEASED CIVILIAN EMPLOYEE

IMPORTANT

Read instructions on back of duplicate before filling in this form

INFORMATION CONCERNING THE EMPLOYEE:

NAME (Last) (First) (Middle)

DATE OF BIRTH (month, day, year)

Social Security Number

DEPARTMENT OR AGENCY IN WHICH EMPLOYED

(Department or agency) (Bureau) (Division)

I, the employee named above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any UNPAID COMPENSATION due and payable after my death. I understand that this Designation of Beneficiary relates solely to money due as defined in 5 U.S.C. 5581, 5582, 5583, and in no way will affect the disposition of any benefit which may become payable under the Retirement or Group Life Insurance Acts applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect until (1) expressly changed or revoked by me in writing, (2) I transfer to another agency, or (3) I am reemployed by the same or another department or agency of the Government.

INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES:

Type or print first name, middle initial, and last name of each beneficiary	Type or print address (including ZIP Code) of each beneficiary	Relationship	Share to be paid to each beneficiary

I hereby direct, unless otherwise indicated above, that, if more than one beneficiary is named, the share of any deceased beneficiary who may predecease me shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. I understand that this Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby specifically reserve the right to cancel or change any designation of beneficiary, at any time, in the manner and form prescribed by the Comptroller General of the United States, and without knowledge or consent of the beneficiary.

(Date of execution--month, day, year) (Signature of employee)

WITNESS TO SIGNATURE:

(Signature of Witness) (Number and street) (City, State, and ZIP Code)

(Signature of Witness) (Number and street) (City, State, and ZIP Code)

PRINT OR TYPE NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYEE

THIS SPACE RESERVED FOR RECEIVING DATA OF EMPLOYING AGENCY

(Indicate date and by whom received)

DELIVER BOTH COPIES TO THE PROPER OFFICER OF YOUR AGENCY--DUPLICATE WILL BE NOTED AND RETURNED

Print back-to-back.

IMPORTANT--The filing of this form will completely cancel any designation you may have previously filed. Be sure to name in this form all persons you wish to designate as beneficiaries of any unpaid compensation payable at your death.

EXAMPLES OF DESIGNATIONS

HOW TO DESIGNATE ONE BENEFICIARY

Type or print first name, middle initial, and last name of each beneficiary	Type or print address (including ZIP Code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Catherine M. Jackson*	2808 Southern Avenue Williams, Indiana 46728	Sister	All

HOW TO DESIGNATE MORE THAN ONE BENEFICIARY

Type or print first name, middle initial, and last name of each beneficiary	Type or print address (including ZIP Code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Susan L. Brown**	110 Prince Street Anniston, New York 14607	Aunt	One-fourth
Mary Joe Carson	230 Duke Street Anniston, New York 14607	Niece	One-fourth
Elizabeth H. Howard	2301 State Street Weaver, Ohio 44405	Mother	One-half

HOW TO DESIGNATE A CONTINGENT BENEFICIARY

Type or print first name, middle initial, and last name of each beneficiary	Type or print address (including ZIP Code) of each beneficiary	Relationship	Share to be paid to each beneficiary
William J. Johnson, if living	244 South Ann Street Olney, Georgia 31204	Father	All
Otherwise to: Sarah L. Johnson	244 South Ann Street Olney, Georgia 31204	Sister	All

HOW TO CANCEL A DESIGNATION OF BENEFICIARY SO THAT AMOUNT DUE WILL BE PAYABLE AS PROVIDED IN THE LAW

Type or print first name, middle initial, and last name of each beneficiary	Type or print address (including ZIP Code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Cancel prior designations			

*** Do not write name as C. M. Jackson or as Mrs. John H. Jackson.**

**** Be sure that the shares to be paid to the several beneficiaries add up to 100 percent.**

Released 6/23/99.

Standard Form 1152
(Rev. 11-91)
Title 4, GAO Manual
1152-108
NSN 7540-00-634-4340

DESIGNATION OF BENEFICIARY

UNPAID COMPENSATION OF DECEASED CIVILIAN EMPLOYEE

IMPORTANT

Read instructions on back of duplicate before filling in this form

INFORMATION CONCERNING THE EMPLOYEE:

NAME (Last)	(First)	(Middle)	DATE OF BIRTH (month, day, year)
			Social Security Number

DEPARTMENT OR AGENCY IN WHICH EMPLOYED

(Department or agency)	(Bureau)	(Division)

I, the employee named above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any UNPAID COMPENSATION due and payable after my death. I understand that this Designation of Beneficiary relates solely to money due as defined in 5 U.S.C. 5581, 5582, 5583, and in no way will affect the disposition of any benefit which may become payable under the Retirement or Group Life Insurance Acts applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect until (1) expressly changed or revoked by me in writing, (2) I transfer to another agency, or (3) I am reemployed by the same or another department or agency of the Government.

INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES:

Type or print first name, middle initial, and last name of each beneficiary	Type or print address (including ZIP Code) of each beneficiary	Relationship	Share to be paid to each beneficiary

I hereby direct, unless otherwise indicated above, that, if more than one beneficiary is named, the share of any deceased beneficiary who may predecease me shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. I understand that this Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby specifically reserve the right to cancel or change any designation of beneficiary, at any time, in the manner and form prescribed by the Comptroller General of the United States, and without knowledge or consent of the beneficiary.

(Date of execution--month, day, year)	(Signature of employee)

WITNESS TO SIGNATURE:

(Signature of Witness)	(Number and street)	(City, State, and ZIP Code)
(Signature of Witness)	(Number and street)	(City, State, and ZIP Code)

PRINT OR TYPE NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYEE	**THIS SPACE RESERVED FOR RECEIVING DATA OF EMPLOYING AGENCY**
	(Indicate date and by whom received)

DELIVER BOTH COPIES TO THE PROPER OFFICER OF YOUR AGENCY--DUPLICATE WILL BE NOTED AND RETURNED

DUPLICATE

Print back-to-back.

IMPORTANT NOTICE--Order of Precedence

If there is no designated beneficiary living, any unpaid compensation which becomes payable after the death of an employee will be payable to the first person or persons listed below who are alive on the date title to the payment arises.

1. To the widow or widower.

2. If neither of the above, to the child or children in equal shares, with the share of any deceased child distributed among the descendants of that child.

3. If none of the above, to the parents in equal shares or the entire amount to the surviving parent.

4. If there are none of the above, to the duly appointed legal representative of the estate of the deceased employee, or if there be none, to the person or persons determined to be entitled thereto under the laws of the domicile of the deceased employee.

It is not necessary for any employee to designate a beneficiary unless he wishes to name some person or persons not included above, or in a different order.

INSTRUCTIONS

1. The examples printed on the back of the first page of this form may be helpful in executing the Designation of Beneficiary.

2. All entries on the form except signatures, should be typed or printed in ink (typewriting preferred). All designations of a beneficiary or beneficiaries should be executed on the prescribed form Designation of Beneficiary, Standard Form 1152, and must be signed and witnessed.

3. Complete the form in duplicate and file with the agency in which employed. A Designation of Beneficiary must be received by the employing agency prior to the death of the designating employee to be valid. The duplicate will be noted and returned to the employee as evidence that the original has been received and filed. It is suggested that the duplicate be filed with the employee's important papers.

4. Cancellation of a prior Designation of Beneficiary may be effected without the naming of a new beneficiary by executing a new Designation of Beneficiary, Standard Form 1152, and inserting in the space provided for name of beneficiary the words, "Cancel prior designation." The effect of this action will require payment to be made in the order of precedence stated above.

5. A designation will remain valid until expressly changed or revoked, until the employee transfers to another agency, or until reemployed by the same or another department or agency of the Government. In case of separation and reemployment, or transfer to another agency, a new Designation of Beneficiary should be executed if the order of precedence established by the act is not acceptable. It is not necessary to file a new designation when the name or address of the employee or the beneficiary is changed.

6. A designation free of erasures or alterations should be filed in order to avoid a possible contest after death.

7. In the absence of the presecribed form, any designation, change, or cancellation of beneficiary witnessed and filed in accordance with the general requirements of these instructions shall be acceptable.

This Designation of Beneficiary form is to be used solely for the disposition of unpaid compensation at death of a civilian employee and is not to be confused with Standard Form 2808, Designation of Beneficiary, Civil Service Retirement System, or Standard Form 2823, Designation of Beneficiary, Federal Employees' Group Life Insurance Program.

THRIFT SAVINGS PLAN
ELECTION FORM

TSP-1

Use this form to start, stop, or change the amount of your contributions to the Thrift Savings Plan (TSP).

Before completing this form, please read the *Summary of the Thrift Savings Plan* and the instructions on the back of this form. Type or print all information. **Return the completed form to your agency personnel or benefits office.**

Note: To choose your investment funds, see the instructions in the General Information section on the back of this form.

I. INFORMATION ABOUT YOU

1. Name *(Last)* *(First)* *(Middle)*

2. Street Address City State Zip Code

3. Social Security Number

4. Daytime Phone (Area Code and Number)

5. Office Identification *(Agency and Organization)*

II. START OR CHANGE YOUR CONTRIBUTIONS

To start or change the amount of your contributions to your TSP account, enter **either** a whole percentage of your basic pay per pay period (Item 6) **or** a whole dollar amount per pay period (Item 7). Skip to Section IV.

6. _____.0% **OR** **7.** $_____.00

III. STOP YOUR CONTRIBUTIONS

To stop your contributions to the TSP, check Item 8 and complete Section IV. (If you are a FERS employee and you are eligible to receive Agency Automatic (1%) Contributions, those 1% contributions will continue. Read the instructions on the back.)

8. ☐ I want to stop contributing to my TSP account. I understand that my payroll contributions will stop no later than the first full pay period after my agency employing office receives this form.

IV. SIGNATURE

9. Participant's Signature

10. Date Signed *(mm/dd/yyyy)*

V. FOR EMPLOYING OFFICE USE ONLY

11. Payroll Office Number

12. Receipt Date *(mm/dd/yyyy)*

13. Effective Date *(mm/dd/yyyy)*

14. Signature of Agency Official

PRIVACY ACT NOTICE. We are authorized to request this information under 5 U.S.C. chapter 84. Executive Order 9397 authorizes us to ask for your Social Security number, which will be used to identify your account. We will use the information you provide on this form to process your TSP election. This information may be shared with other Federal agencies for statistical, auditing, or archiving purposes. In addition, we may share the information with law enforcement agencies investigating a violation of civil or criminal law, or agencies implementing a statute, rule, or order. It may be shared with congressional offices, private sector audit firms, spouses, former spouses, and beneficiaries, and their attorneys. We may also disclose relevant portions of the information to appropriate parties engaged in litigation. You are not required by law to provide this information, but if you do not provide it, we will not be able to process your request.

ORIGINAL TO PERSONNEL FOLDER
Provide a copy to the employee and to the payroll office.

INFORMATION AND INSTRUCTIONS

GENERAL INFORMATION

You may start, stop, or change your contributions at any time. Your TSP election will stay in effect until you submit another election or until you leave Federal service.

Important Note for New TSP Participants: All contributions to your account will be invested in the Government Securities Investment (G) Fund until you direct the TSP to allocate your contributions differently. The Plan Summary describes all of your investment choices and discusses their risks and advantages.

To choose your investment fund(s), use the TSP Web site (www.tsp.gov), the ThriftLine at 1-877-968-3778 (outside the U.S. and Canada, call 404-233-4400), or Form TSP-50, Investment Allocation. If you use the Web site or the ThriftLine, you will need your Social Security number and your TSP Personal Identification Number (PIN). If you are a new participant, you will receive your PIN by mail after your account has been established. If, as a new participant, you choose to submit Form TSP-50, do **not** do so until you receive a letter from the TSP confirming that your new account has been established. If your account has not been established, Form TSP-50 will not be accepted.

If you change your address, notify your **agency** immediately so that your agency can correct your records for your TSP account.

SECTION I

Complete all items in this section.

SECTION II

Complete this section to start your TSP contributions or to change the amount you are contributing to the TSP. Complete **either** Item 6 **or** Item 7.

Item 6, Percentage of Basic Pay per Pay Period. You may contribute up to the Internal Revenue Code (IRC) annual elective deferral limit (e.g., $15,000 in 2006). If you specify a percentage, your contribution amount will automatically increase when you receive a pay raise.

Item 7, Dollar Amount per Pay Period. The dollar amount you contribute cannot exceed the percentages shown above. You can contribute as little as $1 per pay period. If you specify a dollar amount, it will not change until you submit a new Form TSP-1.

SECTION III

Complete this section to stop your contributions. You may restart your contributions at any time.

Note: If you are a FERS employee, you may change the way your Agency Automatic (1%) Contributions are invested even if you are not contributing to your account. You can use the TSP Web site, the ThriftLine, or Form TSP-50, as described in "General Information" above.

SECTION IV

You must complete this section.

SECTION V

(To be completed by personnel or benefits office)

In Item 12, enter the receipt date. This is the date that a **properly completed** form is received by the agency personnel office. If the form has not been properly completed, it should be returned to the employee.

In Item 13, enter the effective date of the election. Elections should be made effective no later than the first full pay period after receipt of a properly completed form.

THRIFT SAVINGS PLAN
DESIGNATION OF BENEFICIARY

TSP-3

Use this form to designate a beneficiary or beneficiaries to receive your civilian Thrift Savings Plan (TSP) account after your death. **Read the instructions on the back to assist you in completing this form.** Type or print the information requested. Do not alter this form or the information you enter; if you need to make a correction or change your entries, start over on a new form. If you have a uniformed services TSP account, you will need to make a separate TSP beneficiary designation for that account on Form TSP-U-3.

I. INFORMATION ABOUT YOU

1. Name _____ (Last) _____ (First) _____ (Middle)

2. _____ Social Security Number **3.** _____ Date of Birth *(mm/dd/yyyy)* **4.** _____ Daytime Phone *(Area Code and Number)*

5. Address _____ Street address or box number

6. _____ City **7.** _____ State/Country **8.** _____ Zip Code

II. DESIGNATING YOUR BENEFICIARIES

Indicate in whole percentages or fractions the share of your TSP account to be paid to each beneficiary.

1. _____ Beneficiary Name *(Last)* _____ *(First)* _____ *(Middle)* **Share:** _____

_____ Street address or box number

_____ City _____ State/Country _____ Zip Code

_____ Social Security Number/EIN _____ Date of Birth *(mm/dd/yyyy)* _____ Relationship

2. _____ Beneficiary Name *(Last)* _____ *(First)* _____ *(Middle)* **Share:** _____

_____ Street address or box number

_____ City _____ State/Country _____ Zip Code

_____ Social Security Number/EIN _____ Date of Birth *(mm/dd/yyyy)* _____ Relationship

3. _____ Beneficiary Name *(Last)* _____ *(First)* _____ *(Middle)* **Share:** _____

_____ Street address or box number

_____ City _____ State/Country _____ Zip Code

_____ Social Security Number/EIN _____ Date of Birth *(mm/dd/yyyy)* _____ Relationship

☞ ☐ Check here if additional pages are used. Number of additional pages _____ (See back of form.)

III. YOUR SIGNATURE

Sign and date this section. Your signature must be witnessed in Section IV.

_____ Participant's Signature _____ Date Signed

IV. WITNESSES TO SIGNATURE

This form is valid only if it is witnessed by two persons. The witnesses must be age 21 or older. (A witness cannot be a beneficiary of any portion of this TSP account.) By signing below, the witnesses affirm that the participant: (a) signed Section III in their presence, or (b) informed them that the signature in Section III is the participant's own signature.

Witness **1** _____ Typed or Printed Name of First Witness _____ Signature of First Witness

Witness **2** _____ Typed or Printed Name of Second Witness _____ Signature of Second Witness

INFORMATION AND INSTRUCTIONS

Make a copy of this form for your records. Mail the original to:

TSP Service Office
P.O. Box 385021
Birmingham, AL 35238

Or fax the completed form to our toll-free fax number:
1-866-817-5023

If you have questions, call the (toll-free) ThriftLine at 1-TSP-YOU-FRST (1-877-968-3778) or TDD: 1-TSP-THRIFT5 (1-877-847-4385). Outside the United States and Canada, please call 404-233-4400 (not toll free).

Your quarterly participant statement will show the date of your most recent designation.

Designating a beneficiary. This Designation of Beneficiary form applies **only** to the disposition of your civilian Thrift Savings Plan (TSP) account after your death. It does not affect the disposition of your FERS Basic Annuity, your CSRS annuity, your uniformed services TSP account (if you have one), or any other benefits.

It is necessary to designate a beneficiary only if you want payment to be made in a way other than the following order of precedence:

1. To your widow or widower.
2. If none, to your child or children equally, and descendants of deceased children by representation.
3. If none, to your parents equally or to the surviving parent.
4. If none, to the appointed executor or administrator of your estate.
5. If none, to your next of kin who is entitled to your estate under the laws of the state in which you resided at the time of your death.

In this order of precedence, a child includes a natural child (even if the child was born out of wedlock) and a child adopted by the participant; it does not include a stepchild who was not adopted. Note: If the participant's natural child was adopted by someone other than the participant's spouse, that child is not entitled to a share of the participant's TSP account under the statutory order of precedence. "By representation" means that if a child of the participant dies before the participant dies, that child's share will be divided equally among his or her children. Parent does not include a stepparent, unless the stepparent adopted the participant.

Making a valid designation. To name beneficiaries to receive your TSP account after you die, you must complete this form, and it must be received by the TSP on or before the date of your death. **Only** Form TSP-3 is valid for designating a beneficiary to your civilian TSP account; a will is not valid for the disposition of a TSP account. You may, however, designate your estate or a trust as a beneficiary on Form TSP-3.

You are responsible for ensuring that your Form TSP-3 is properly completed, signed, and witnessed (see the Instructions for Sections II and IV in the right-hand column). Do not submit an altered form; if you need to correct or change the information you have entered on the form, start over on a new form.

Changing or cancelling your designation of beneficiary. This Designation of Beneficiary will stay in effect until you submit another valid Form TSP-3 naming other beneficiaries or cancelling prior designations. To cancel a Form TSP-3 already on file, write "Cancel prior designations" in Section II of a new Form TSP-3, sign and date the form, and have it witnessed.

Keep your designation (and your beneficiaries' addresses) current. If your family status changes due to marriage, birth or adoption of a child, divorce, or death, you may want to change your designation.

If your beneficiaries predecease you. The share of any beneficiary who dies before you die will be distributed proportionally among the surviving designated TSP beneficiaries unless a designated contingent beneficiary is alive at your death. If none of your designated beneficiaries is alive at the time of your death, the standard order of precedence will be followed.

INSTRUCTIONS FOR SECTION II. You may name as a beneficiary any person, corporation, trust, or legal entity, or your estate. Note: If the beneficiary is a minor child, benefits will be made payable directly to the child.

If you need more space, use a blank sheet of paper. Enter your name, Social Security number, and date of birth, and number the pages. You must sign and date **all** additional pages; the same two witnesses who signed the form must sign each additional page.

Enter the share for each beneficiary as a whole percentage or a fraction. Percentages must total 100 percent; fractions must total 1.

The examples show you how to name a beneficiary or cancel prior Designations of Beneficiary.

- For each person you designate as a beneficiary, enter the full name, share, address, Social Security number (SSN), date of birth, and relationship to you. If you do not have all the requested information, you must provide at least the beneficiary's name, the beneficiary's share, and either the SSN or date of birth.
- You may designate one or more contingent beneficiaries for each primary beneficiary you name on Form TSP-3. The contingent beneficiary will receive the primary beneficiary's share if the primary beneficiary dies before you do. (You cannot designate contingent beneficiaries for contingent beneficiaries.)
- If the beneficiary is a corporation or other legal entity, enter the name of the entity on the name line. Enter the legal representative's name and address on the address lines. Enter the Employer Identification Number (EIN). Leave the date of birth and relationship blank.
- If the beneficiary is a trust, enter the name of the trust on the name line. Enter the trustee's name and address on the address lines. Enter the EIN, if available. Leave date of birth blank. Enter "Trust" on the relationship line. Note: Filling out this form will not create a trust.
- If the beneficiary is an estate, enter the name of the estate on the name line. Enter the executor's name and address on the address lines. Enter the EIN, if available. Leave date of birth blank. Enter "Estate" on the relationship line.
- You may cancel a designation of beneficiary by printing "Cancel prior designation" on the name line. Note: If you do not submit another Form TSP-3, your account will be paid according to the order of precedence.

INSTRUCTIONS FOR SECTION IV. Do not ask the individuals you name as beneficiaries of your TSP account to witness your Form TSP-3. A person named as a beneficiary of this TSP account who is also a witness cannot receive his or her share of this TSP account.

EXAMPLES OF DESIGNATING A BENEFICIARY

A. DESIGNATING ONE BENEFICIARY

1. **Morgan** (Name *(Last)*) **Katherine** (*(First)*) **Anne** (*(Middle)*) **Share: 100%**

1279 Lake Avenue (Street address or box number)

New Orleans (City) **LA** (State/Country) **70124** (Zip Code)

923-45-6789 (Social Security Number/EIN) **6 / 22 / 1942** (Date of Birth *(mm/dd/yyyy)*) **Sister** (Relationship)

Enter the full name of the beneficiary. Do not write name as K.A. Morgan or as Mrs. Keith H. Morgan.

B. DESIGNATING MORE THAN ONE BENEFICIARY

1. **Larson** (Name *(Last)*) **Susan** (*(First)*) **Maria** (*(Middle)*) **Share: ¼**

4231 Oregano Street (Street address or box number)

Cincinnati (City) **OH** (State/Country) **45239** (Zip Code)

934-56-7890 (Social Security Number/EIN) **9 / 7 / 1950** (Date of Birth *(mm/dd/yyyy)*) **Sister** (Relationship)

Be sure that the shares to be paid to the beneficiaries total 100 percent if using percentages, or 1 if using fractions.

2. **Larson** (Name *(Last)*) **Elliott** (*(First)*) **Harris** (*(Middle)*) **Share: ¼**

4231 Oregano Street (Street address or box number)

Cincinnati (City) **OH** (State/Country) **45239** (Zip Code)

945-67-8901 (Social Security Number/EIN) **4 / 20 / 1952** (Date of Birth *(mm/dd/yyyy)*) **Brother** (Relationship)

3. **Steinway** (Name *(Last)*) **Sarah** (*(First)*) **Ruth** (*(Middle)*) **Share: ½**

P.O. Box 812 (Street address or box number)

Covington (City) **KY** (State/Country) **40117** (Zip Code)

956-78-9012 (Social Security Number/EIN) **12 / 2 / 1960** (Date of Birth *(mm/dd/yyyy)*) **Friend** (Relationship)

If you use additional pages, be sure to put your name, Social Security number, and date of birth on each page. You and the same two witnesses who signed the form must sign each additional page. Put the date you signed the form on each additional page.

Detach here

C. DESIGNATING ONE OR MORE CONTINGENT BENEFICIARIES

If living:

1. **Kraus** (Name *(Last)*) **Michael** (*(First)*) **Thomas** (*(Middle)*) **Share: 100%**

6287 Laurel Post Drive (Street address or box number)

Stone Mountain (City) **GA** (State/Country) **30058** (Zip Code)

967-89-0123 (Social Security Number/EIN) **3 / 12 / 1936** (Date of Birth *(mm/dd/yyyy)*) **Father** (Relationship)

Otherwise to:

2. **Kraus** (Name *(Last)*) **Cecilia** (*(First)*) **Jean** (*(Middle)*) **Share: 50%**

6287 Laurel Post Drive (Street address or box number)

Stone Mountain (City) **GA** (State/Country) **30058** (Zip Code)

978-90-1234 (Social Security Number/EIN) **8 / 16 / 1968** (Date of Birth *(mm/dd/yyyy)*) **Daughter** (Relationship)

And to:

3. **Richardson** (Name *(Last)*) **Melissa** (*(First)*) **Anne** (*(Middle)*) **Share: 50%**

9842 Magnolia Drive (Street address or box number)

Columbus (City) **GA** (State/Country) **30161** (Zip Code)

989-01-2345 (Social Security Number/EIN) **11 / 6 / 1970** (Date of Birth *(mm/dd/yyyy)*) **Daughter** (Relationship)

You may designate one or more contingent beneficiaries to receive a beneficiary's share if the primary beneficiary dies before you do. To identify the primary and contingent beneficiaries, you must write in "If living:" above the primary beneficiary's name and "Otherwise to:" above the contingent beneficiary's name. If there is more than one contingent beneficiary for a primary beneficiary, write in "And to:" above the second (and subsequent) beneficiary's name.

In this example, Melissa Richardson and Cecilia Kraus are both contingent beneficiaries for Michael Kraus.

Note: If a named beneficiary dies, you may prefer to submit another Form TSP-3 to change your designation(s).

EXAMPLES OF DESIGNATING A BENEFICIARY (continued)

D. DESIGNATING A CORPORATION OR LEGAL ENTITY

1. **The XYZ Foundation** — Share: **100%**
   Name [Name of corporation or legal entity]
   c/o Eleanor Jarvis, Legal Representative 64730 Connecticut Ave.
   Street address or box number [Name of Legal Representative and Legal Representative's address]
   Bethesda | **MD** | **20815**
   City | State/Country | Zip Code
   99-0123456 | [Leave blank] | [Leave blank]
   Social Security Number/EIN | Date of Birth *(mm/dd/yyyy)* | Relationship

E. DESIGNATING A TRUST

1. **John P. Manos Trust** — Share: **100%**
   Name [Name of trust]
   c/o Eric P. Manos, Trustee 1111 Delaware Lane
   Street address or box number [Name of Trustee and Trustee's address]
   New York | **NY** | **14607**
   City | State/Country | Zip Code
   92-3456789 | [Leave blank] | **Trust**
   Social Security Number/EIN | Date of Birth *(mm/dd/yyyy)* | Relationship

F. DESIGNATING AN ESTATE

1. **Estate of Ruth R. Jones** — Share: **100%**
   Name [Name of estate]
   c/o Marilyn D. McClain, Executor 150 Rossmoyne Drive
   Street address or box number [Name of Executor and Executor's address]
   Alameda | **CA** | **94510**
   City | State/Country | Zip Code
   93-1234567 | [Leave blank] | **Estate**
   Social Security Number/EIN | Date of Birth *(mm/dd/yyyy)* | Relationship

G. CANCELLING A DESIGNATION OF BENEFICIARY

1. **Cancel prior designations** — Share: _____
   Name *(Last)* *(First)* *(Middle)*
   Street address or box number
   City | State/Country | Zip Code
   _____ | ___/___/_____ | _____
   Social Security Number/EIN | Date of Birth *(mm/dd/yyyy)* | Relationship

This will cause your account to be paid according to the order of precedence (unless you submit another Form TSP-3).

Be sure your form cancelling prior designations is signed, dated, and witnessed.

PRIVACY ACT NOTICE. We are authorized to request this information under 5 U.S.C. chapter 84. Executive Order 9397 authorizes us to ask for your Social Security number, which will be used to identify your account. We will use the information you provide on this form to document your choice of beneficiary or beneficiaries to receive your account after your death. This information may be shared with other Federal agencies for statistical, auditing, or archiving purposes. In addition, we may share the information with law enforcement agencies investigating a violation of civil or criminal law, or agencies implementing a statute, rule, or order. It may be shared with congressional offices, private sector audit firms, spouses, former spouses, and beneficiaries, and their attorneys. We may also disclose relevant portions of the information to appropriate parties engaged in litigation. You are not required by law to provide this information, but if you do not provide it, we will not be able to document your choice of beneficiary(ies).

SELF-IDENTIFICATION OF HANDICAP

(See instructions and Privacy Act information on reverse)

Last Name, First Name, Middle Initial	Birth Date *(Mo./Yr.)*	Social Security Number	ENTER CODE HERE →

DEFINITION OF A HANDICAP: A person is handicapped if he or she has a physical or mental impairment which substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment. Those handicaps that are to be reported are listed below (codes in bold numbers 13 through 94). In the case of multiple impairments, choose the code which describes the impairment that would result in the most substantial limitation.

TO THE EMPLOYEE: Self-identification of handicap status is essential for effective data collection and analysis. The information you provide will be used for statistical purposes only and will not in any way affect you individually. While self-identification is voluntary, your cooperation in providing accurate information is critical.

01 I do not wish to identify my handicap status. *(Please read the employee note above and the reverse side of this form before using this code.)* (Note: Your personnel officer may use this code if, in his or her judgment, you used an incorrect code.)

05 I do not have a handicap.

06 I have a handicap but it is not listed below.

SPEECH IMPAIRMENTS

13 Severe speech malfunction or inability to speak; hearing is normal *(Examples: defects of articulation [unclear language sounds]; stuttering; aphasia [impaired language function]; laryngectomy [removal of the "voice box"])*

HEARING IMPAIRMENTS

15 Hard of hearing *(Total deafness in one ear or inability to hear ordinary conversation, correctable with a hearing aid)*

16 Total deafness in both ears, with understandable speech

17 Total deafness in both ears, and unable to speak clearly

VISION IMPAIRMENTS

22 Ability to read ordinary size print with glasses, but with loss of peripheral (side) vision *(Restriction of the visual field to the extent that mobility is affected—"Tunnel vision")*

23 Inability to read ordinary size print, not correctable by glasses *(Can read oversized print or use assisting devices such as glass or projector modifier)*

24 Blind in one eye

25 Blind in both eyes *(No usable vision, but may have some light perception)*

MISSING EXTREMITIES

27 One hand
28 One arm
29 One foot
32 One leg
33 Both hands or arms
34 Both feet or legs
35 One hand or arm *and* one foot or leg
36 One hand or arm *and* both feet or legs
37 Both hands or arms *and* one foot or leg
38 Both hands or arms *and* both feet or legs

NONPARALYTIC ORTHOPEDIC IMPAIRMENTS

(Because of chronic pain, stiffness, or weakness in bones or joints, there is some loss of ability to move or use a part or parts of the body.)

44 One or both hands
45 One or both feet
46 One or both arms
47 One or both legs
48 Hip or pelvis
49 Back
57 Any combination of two or more parts of the body

PARTIAL PARALYSIS

(Because of a brain, nerve, or muscle problem, including palsy and cerebral palsy, there is some loss of ability to move or use a part of the body, including legs, arms, and/or trunk.)

61 One hand
62 One arm, any part
63 One leg, any part
64 Both hands
65 Both legs, any part
66 Both arms, any part
67 One side of body, including one arm and one leg
68 Three or more major parts of the body *(arms and legs)*

COMPLETE PARALYSIS

(Because of a brain, nerve, or muscle problem, including palsy and cerebral palsy, there is a complete loss of ability to move or use a part of the body, including legs, arms, and/or trunk.)

70 One hand
71 Both hands
72 One arm
73 Both arms
74 One leg
75 Both legs
76 Lower half of body, including legs
77 One side of body, including one arm and one leg
78 Three or more major parts of the body *(arms and legs)*

OTHER IMPAIRMENTS

80 Heart disease with no restriction or limitation of activity *(History of heart problems with complete recovery)*

81 Heart disease with restriction or limitation of activity

82 Convulsive disorder *(e.g., epilepsy)*

83 Blood diseases *(e.g., sickle cell anemia, leukemia, hemophilia)*

84 Diabetes

86 Pulmonary or respiratory disorders *(e.g., tuberculosis, emphysema, asthma)*

87 Kidney dysfunctioning *(e.g., if dialysis [Use of an artificial kidney machine] is required)*

88 Cancer—a history of cancer with complete recovery

89 Cancer—undergoing surgical and/or medical treatment

90 Mental retardation *(A chronic and lifelong condition involving a limited ability to learn, to be educated, and to be trained for useful productive employment as certified by a State Vocational Rehabilitation agency under section 213.3102(t) of Schedule A)*

91 Mental or emotional illness *(A history of treatment for mental or emotional problems)*

92 Severe distortion of limbs and/or spine *(e.g., dwarfism, kyphosis [severe distortion of back])*

93 Disfigurement of face, hands, or feet *(e.g., distortion of features on skin, such as those caused by burns, gunshot injuries, and birth defects [gross facial birthmarks, club feet, etc.])*

94 Learning disability *(A disorder in one or more of the processes involved in understanding, perceiving, or using language or concepts [spoken or written]; e.g., dyslexia)*

The Rehabilitation Act of 1973 (P.L. 93-112) requires each agency in the Executive branch of the Federal Government to establish definite programs that will facilitate the hiring, placement, and advancement of handicapped individuals. The best means of determining agency progress in this respect is through the production of reports at certain intervals showing such things as the number of handicapped employees hired, promoted, trained, or reassigned over a given time period; the percentage of handicapped employees in the work force and in various grades and occupations; etc. Such reports bring to the attention of agency top management, the Office of Personnel Management (OPM), and the Congress deficiencies within specific agencies or the Federal Government as a whole in the hiring, placement, and advancement of handicapped individuals and, therefore, are the essential first step in improving these conditions and consequently meeting the requirements of the Rehabilitation Act.

The handicap data collected on employees will be used only in the production of reports such as those previously mentioned and not for any purpose that will affect them individually. The only exception to this rule is that the records may be used for selective placement purposes and selecting special populations for mailing of voluntary personnel research surveys. In addition, every precaution will be taken to ensure that the information provided by each employee is kept in the strictest confidence and is known only to the one or two individuals in the agency Personnel Office who obtain and record the information for entry into the agency's and OPM's personnel systems. You should also be aware that participation in the handicap reporting system is entirely voluntary, **with the exception of employees appointed under Schedule A, section 213.3102(t) (Mental Retardation); Schedule A, section 213.3102(u) (Severely Physically Handicapped); and Schedule B, section 213.3202(k) (Mentally Restored).** These employees will be requested to identify their handicap status and if they decline to do so, their correct handicap code will be obtained from medical documentation used to support their appointment. No other employees will be required to identify their handicap status if they feel for any reason it is not in their best interest to have this information officially recorded outside of medical records. We request only that anyone not wishing to have this information entered in the agency's and OPM's personnel systems indicate this to their Personnel Office, rather than intentionally miscoding themselves, since false responses will seriously damage the statistical value of the reporting system.

[In those instances where the employee is or was hired under Schedule A, section 213.3102(t) (Mental Retardation), the Personnel Director or his/her designee (a Vocational Rehabilitation Counsefor may also be helpful) **will assist the individual in completing this form and ensure that the employee fully understands the meaning of the form and the options available to him/her, as noted above.**]

Employees will be given every opportunity to ensure that the handicap code carried in their agency's and OPM's personnel systems is accurate and is kept current. They may exercise this opportunity by asking their Personnel Officer to see a printout of the code and definition from their record, by notifying Personnel any time their handicap status changes, and by initiating action in either of these cases to have the necessary changes made to their records. The code carried on employees in their agency's system will be identical to that carried in OPM's system, and any change to the agency records will result in the same change being made to OPM's records.

Your cooperation and assistance in establishing and maintaining an accurate and up-to-date handicap report system is sincerely appreciated.

PRIVACY ACT STATEMENT

Collection of the requested information is authorized by the Rehabilitation Act of 1973 (P.L. 93-112). The information you furnish will be used for the purpose of producing statistical reports to show agency progress in hiring, placement, and advancement of handicapped individuals and to locate individuals for voluntary participation in surveys. The reports will be used to inform agency top management, the Office of Personnel Management (OPM), the Congress, and the public of the status of programs for employment of the handicapped. All such reports will be in the form of aggregate totals and will not identify you in any way as an individual.

Solicitation of your Social Security Number (SSN) is authorized by Executive Order 9397, which requires agencies to use the SSN as the means for identifying individuals in personnel information systems. Your SSN will only be used to ensure that your correct handicap code is recorded along with the other employee information that your agency and OPM maintain on you. Furnishing your SSN or any other of the requested data for this collection effort is voluntary and failure to do so will have no effect on you. It should be noted, however, that where individuals decline to furnish their SSN, the SSN will be obtained from other records in order to ensure accurate and complete data.

Employees appointed under Schedule A, section 213.3102(t) (Mental Retardation), Schedule A, section 213.3102(u) (Severely Physically Handicapped), or Schedule B, section 213.3202(k) (Mentally Restored) are requested to furnish an accurate handicap code, but failure to do so will have no effect on them. Where employees hired under one of these appointments fail to disclose their handicap, however, the appropriate code will be determined from the employee's existing records or medical documentation submitted to justify the appointment.

Save Form As | Save Form | Print Forms

★U.S.GPO:1991-0-290-490/20214