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)*: PASTOR, RACHEL, A.
2. Social Security Number: 138-02-7848
3. Date of birth *(mm/dd/yyyy)*: 08/29/1996
4. Sex: ☐ M ☑ F
5. Are you married? ☐ Yes ☑ No
6. Home mailing address *(including ZIP Code)*: 1657B N. VAN DORN STREET, ALEXANDRIA, VA 22304
7. If you are covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
8. Medicare Beneficiary Identifier
9. Are you covered by insurance other than Medicare? ☐ Yes, indicate in item 10 below. ☑ No
10. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*
11. Email address: RACHEL.PASTOR19@GMAIL.COM
12. Preferred telephone number: (732)804-8478
13. Name of family member *(last, first, middle initial)*
14. Social Security Number
15. Date of birth *(mm/dd/yyyy)*
16. Sex: ☐ M ☐ F
17. Relationship code
18. Address *(if different from enrollee)*
19. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
20. Medicare Beneficiary Identifier
21. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 22 below. ☐ No
22. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*
23. Email address *(if applicable, enter email address of your spouse or adult child)*
24. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*
25. Name of family member *(last, first, middle initial)*
26. Social Security Number
27. Date of birth *(mm/dd/yyyy)*
28. Sex: ☐ M ☐ F
29. Relationship code
30. Address *(if different from enrollee)*
31. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
32. Medicare Beneficiary Identifier
33. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 34 below. ☐ No
34. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*
35. Email address *(if applicable, enter email address of your spouse or adult child)*
36. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*
37. Name of family member *(last, first, middle initial)*
38. Social Security Number
39. Date of birth *(mm/dd/yyyy)*
40. Sex: ☐ M ☐ F
41. Relationship code
42. Address *(if different from enrollee)*
43. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
44. Medicare Beneficiary Identifier
45. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 46 below. ☐ No
46. Indicate the type(s) of other insurance
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*
47. Email address *(if applicable, enter email address of your spouse or adult child)*
48. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

(Continued on the reverse)

Enrollee name: PASTOR, RACHEL, A. Date of birth: 08/29/1996

Part B - FEHB Plan You Are Currently Enrolled In *(if applicable)*

1. Plan name	2. Enrollment code

Part C - FEHB Plan You Are Enrolling In or Changing To

1. Plan name	2. Enrollment code
Blue Cross and Blue Shield Service Benefit Plan - Basic 11 - 111	111

Part D - Event That Permits You To Enroll, Change, or Cancel *(see page 6)*

1. Event code	2. Date of event
1A	03/26/2023

Part E - Election NOT to Enroll *(Employees Only)*

☐ I do NOT want to enroll in the FEHB Program.
My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.

Part F - Cancellation of FEHB

☐ I CANCEL my enrollment.
My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.

Part G - Suspension of FEHB *(Annuitants/Former Spouses Only)*

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

Part H - Signature

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*	2. Date *(mm/dd/yyyy)*
Electronically signed by Rachel A Pastor	04/04/2023 12:23 pm

Part I -To be completed by agency or retirement system

REMARKS

New Hire

1. Date received *(mm/dd/yyyy)*	2. Effective date of action *(mm/dd/yyyy)*	3. Personnel telephone number
04/03/2023	03/26/2023	(303)969-7407

4. Name and address of agency or retirement system	5. Authorizing official *(please print)*
Department of Transportation 800 INDEPENDENCE AVE SW ROOM 523 WASHINGTON , DC 20591	Tiwanda Yarborough
	6. Signature of authorized agency official Electronically signed by TIWANDA L YARBOROUGH (HUMAN RESOURCES SPECIALIST)

7. Payroll office number	8. Payroll office contact *(please print)*	9. Payroll telephone number
69149999	Rose Alozian	(303)969-7407