Sample Notice

FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB)

Request to Remove a Family Member from FEHB Enrollment

Family Member Type: Spouse

A spouse may be removed from a Self Plus One or Self and Family enrollment if a request is submitted to the enrollee's agency for approval. The request must include a Health Benefits Election Form (Standard Form (SF) 2809) and a notarized statement signed by both the enrollee and the spouse. A draft statement is attached.

The enrollee must complete the following sections of the SF 2809;

a. Part A (lines 1-12 , and specific information for family member(s) being removed starting with line 13)
b. Part B
c. Part H

A spouse's removal is considered a cancellation. The removed spouse is not eligible for the 31-day temporary extension of coverage, conversion to an individual policy, or temporary continuation of coverage (TCC). Eligibility for family members to continue the enrollee's health benefits enrollment after the enrollee's death may be impacted. See your employing office for additional information.

A removed spouse may only regain coverage under the applicable Self Plus One or Self and Family enrollment if requested by the enrollee during the annual Federal Benefits Open Season or within 60 days of the family member losing other health insurance coverage. The enrollee must provide written consent to reinstatement of coverage from the spouse and demonstrate eligibility of the spouse as a family member.

The effective date of removal is the first day of the third pay period following the date the request is approved by the agency for enrollees who pay bi-weekly and the second pay period following the date that the request is approved by the agency for enrollees who pay premiums monthly.

Submit the appropriate request, to your agency.

FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB)

Request to Remove a Spouse from FEHB Enrollment

Family Member Type: Spouse

Name of Enrollee:

Name of FEHB Health Plan/Enrollment Code:

Name of Spouse:

We are requesting that the above named family member be removed from the above named enrollee's FEHB coverage. By our signatures we acknowledge that this is a voluntary action and we understand the impact this will have on the family member's FEHB coverage and ability to regain FEHB coverage in the future.

_____ _____

(Signature - Enrollee) (Date)

_____ _____

(Signature – Spouse) (Date)

On this, the_____day of _____, 20____, before me a notary public, the undersigned officer, personally appeared_____, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained.

In witness hereof, I hereunto set my hand and official seal.

_____

Notary Public