Sample 1

NOTICE OF ISSUE WITH FAMILY ENROLLMENT

Name of Enrollee
Street Address
City, State and Zip

ID Number:
Social Security Number:

Dear {*name of enrollee*},

We are in the process of reconciling our Federal Employees Health Benefits (FEHB) enrollment records with the records of {*person's employing agency*}. Your agency or retirement system shows you are enrolled in a Self and Family enrollment. Our records indicate you are currently the only person covered under your enrollment. If you have a spouse or children that we do not know about, please call us and provide each individual's information. The phone number is {*Plan phone number*}.

If you are the only person covered (e.g., you divorced and there are no children to cover or you are a single parent and your youngest child is now age 26 or over), then you are eligible to change to a Self Only enrollment. If you change to a Self Only enrollment, the premium you pay will be substantially less. Your employing office or retirement system may allow your change to Self Only retroactively and refund the difference in premium between Self and Family and Self Only.

In order to have your enrollment changed to Self Only, you have to contact your Human Resources (HR) office or retirement system and request to have your FEHB enrollment changed to Self Only. Your HR office or retirement system will not make this change automatically for you or initiate the enrollment change on your behalf. You have to request the enrollment change.

Marriage or adding an eligible family member is a Qualifying Life Event (QLE) that will allow you to change your enrollment back to Self and Family at that time even after you have retired.

Changing your enrollment to Self Only will give you the same health coverage you are getting now with your Self and Family enrollment, but will cost you less.

Thank you.

Sincerely,

Sample 2

NOTICE OF ASSISTANCE LETTER

Name of Enrollee
Street Address
City, State and Zip

ID Number:
Social Security Number:

Dear {*name of enrollee*},

We are in the process of reconciling our Federal Employees Health Benefits (FEHB) enrollment records with the records of {*person's employing agency*}. Our records indicate that you are currently enrolled in our Health Benefits Plan through {*person's employing agency*}, but the information provided by {*person's employing agency*} shows that you are enrolled in our Plan through a different enrollment code than the code demonstrated in our records. The enrollment code indicates whether you are enrolled in Self and Family or Self Only coverage, and which option of coverage you are enrolled in.

Please provide us with appropriate documentation verifying your current, valid enrollment code with our Plan. Appropriate documentation includes:

- A copy of your Standard Form 2809 (basic enrollment document) or Standard Form 2810 (notice of change in enrollment) demonstrating your enrollment code for this Plan;
- A copy of a letter confirming your electronic enrollment transaction such as Employee Express or the Annuitant Confirmation Letter that indicates your enrollment code for this Plan;
- A copy of a recent earnings and leave statement, or annuity statement, showing withholding for this Plan; or
- A document or other credible information from your employing office or retirement system stating that you are entitled to continued enrollment in this Plan through the enrollment code reported by your employing office or retirement system and that the premiums are being withheld for that enrollment code.

Send or bring the appropriate documentation to:

{*Plan name and address, and phone number*}

Please call the telephone number above and identify your current or former payroll office, so that we may contact them for any appropriate documentation.

Thank you for your assistance with this reconciliation. We regret any inconvenience this may cause you. If you have any questions, please call us at {*Plan phone number*}. Thank you.

Sincerely,

Sample 3

NOTICE OF INTENT TO DISENROLL

Name of Enrollee
Street Address
City, State and Zip

ID Number:
Social Security Number:

Dear (*name of enrollee*),

We are in the process of reconciling our Federal Employees Health Benefits (FEHB) enrollment records with the records of {*person's employing agency*}. Our records indicate that you are currently enrolled in our Health Benefits Plan through {*person's employing agency*}, but the information provided by this agency does not show you as being enrolled in our Plan.

You must provide us with appropriate documentation verifying your current, valid enrollment with our Plan. You have 31 days from the date of this letter to provide us with this documentation. If we do not hear positively from you within the 31-day period, we will then disenroll you from our Plan. We will not disenroll you until the 31-day period expires. Appropriate documentation includes:

- A copy of the Standard Form 2809 (basic enrollment document) or Standard Form 2810 (notice of change in enrollment);
- A copy of a letter confirming an electronic enrollment transaction such as Employee Express or the Annuitant Confirmation Letter;
- A copy of a recent earnings and leave statement showing withholding for this Plan; or
- A document or other creditable information from your employing office stating that you are entitled to continued enrollment in this Plan and that the premiums are being withheld.

Send or bring the appropriate documentation to:

{*Plan name and address, and phone number}*

If you are no longer enrolled in our Health Benefits Plan, please call and tell us. The reasons you might not be enrolled in our Plan include:

- You have changed your enrollment to another carrier;
- You have separated from Federal employment and are no longer eligible for FEHB enrollment; or
- You cancelled your enrollment.

Please call the number above and identify your current or former payroll office, so that we may contact them for any appropriate documentation.

Check the Social Security Number (SSN) shown above. If this is not your SSN, call us immediately and ask us to correct your number.

If we disenroll you and you believe we should not have disenrolled you, you may ask your employing office or retirement system to reconsider our decision. The request must be made in writing and must include your name, address, Social Security Number, Retirement Claim Number (if applicable), the name of the Health Benefits Carrier, and the reason(s) for your request for reinstatement. The request for reconsideration must be filed within 60 calendar days from the date of this disenrollment notice.

We regret any inconvenience this may cause you. If you have any questions, please call us at {*Plan phone number}*. Thank you.

Sincerely,