



Direct Premium Remittance System (DPRS)



PUBLICATION CATEGORY
Insurance Processing

PROCEDURE MANUAL
Direct Premium Remittance System (DPRS)



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Latest Update Information

The following changes have been made to the Direct Premium Remittance System (DPRS) procedure:

Section	Description of Change
DPRS	Procedure document has been updated throughout to be accessible with assistive technology according to Section 508 of the Rehabilitation Act.



Introduction

This procedure provides instructions for Federal Agencies to enroll eligible non-Federally employed individuals in the Direct Premium Remittance System (DPRS). DPRS is a centralized system for collecting premiums from eligible non-Federal enrollees who elect to participate in the Federal Employees Health Benefits (FEHB) Program under Public Law (P.L.) is described below, see *Appendix I, Public Laws Guidelines* (on page 87).

- P.L. 98-615 (5 USC 8905a), Civil Service Retirement Spouse Equity Act of 1984, provides for the enrollment of eligible former spouses of current, retired, or separated Federal employees in FEHB program.
- Title II of P.L. 100-654 (5 USC 8905a), Federal Employees Health Benefits Amendments Act of 1988, provides for temporary continuation of coverage (TCC) under FEHB for (1) certain individuals who separate from Federal service, (2) children (of Federal employees, annuitants, or separated employees already enrolled in FEHB) who lost their status as family members, and (3) certain former spouses of current or separated Federal employees or annuitants who would otherwise not be eligible for continued FEHB coverage.
- P.L. 101-303 (5 USC 8906I), Direct Pay Annuitant/Survivors, provides for annuitants/survivors to pay health benefits premiums directly to the National Finance Center (NFC) when the annuity is insufficient to pay the withholdings for the plan that the annuitant/survivor is enrolled.
- P.L. 102-484, National Defense Authorization Act for Fiscal Year 1993, amends the TCC under FEHB for certain civilian employees of the Department of Defense (DOD) separated under the reduction in force.
- P.L. 104-106, National Defense Authorization Act for Fiscal Year 1996, amends the TCC under FEHB to cover employees who voluntarily separate from surplus positions.

Each of these laws establishes a requirement that Agencies provide FEHB coverage for qualified enrollees. The Office of Personnel Management (OPM) has contracted with the United States Department of Agriculture's (USDA) NFC to act as the central processing office for P.L. 98-615 and P.L. 100-654 accounts. Those Agencies that elect to use NFC's services will have their accounts processed through DPRS.

Only annuitants and survivors on direct-pay are serviced by NFC.

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Background

The Direct Premium Remittance System (DPRS) is a centralized system for billing and collecting premiums from eligible non-Federal enrollees who elect to participate in FEHB and Federal annuitants/survivors who are placed in direct-pay due to insufficient net annuity pay.

Overall Functional Description of Direct Premium Remittance Web (DPRW)

Previously, DPRS functionality was a manual process. DPRW is an Oracle Web-based front end to accommodate the functions performed by Payroll Offices, Human Resources (HR), individual enrollee's NFC Administrators, and OPM personnel.

The purpose is to design, develop, and implement an Oracle Web-based front end for DPRW to mimic the functionality for both Standard Form (SF) 2809, Health Benefits Election, see *SF 2809, Health Benefits Election Form* (on page 70) and SF 2810, Notice of Change in Health Benefits, see *SF 2810, Notice of Change in Health Benefits Enrollment* (on page 73). All data that Agencies are currently completing on the hard copy SF 2809 form will be entered into the DPRW portal pages. Agency officials will be required to certify the document through the portal, thus confirming eligibility for the FEHB enrollment.

The Benefits of DPRW:

DPRW will increase efficiency of the TCC enrollment process by eliminating mailing and faxing of hard copy enrollments. Having HR Offices enter their own documents will significantly decrease the time it takes an enrollee to get enrolled by the carrier and receive ID cards and billing coupons. Original hard copies will no longer need to be sent to NFC. This is also a savings in postage costs.

Resources

A DPRW participant guide is available from the DPRS Web site at https://www.nfc.usda.gov/Training/Resources/DPRW_Participant_Guide.pdf. Users are encouraged to read the guide in advance of receiving their user ID and password from NFC Security.



Responsibilities

This section explains the responsibilities of the primary organizations involved in data processing and system maintenance.

This section includes the following topics:

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National Finance Center (NFC) Responsibilities.....	6

Agencies Responsibilities

Below are the responsibilities of the primary organizations.

Agency submitting offices will:

- Inform separating employees of their eligibility and that of their children and former spouses under the expanded FEHB coverage.
- Inform separating employees of the eligibility time restraints imposed under the expanded FEHB coverage. (See Federal Personnel Manual (FPM) bulletins 890-179 and 890-186 for information on eligibility.)
- Determine the eligibility of separated employees, children, and former spouses of current employees for the expanded FEHB coverage. (See FPM bulletins 890-179 and 890-186 for information on eligibility.)
- Determine the eligibility of separated employees, children, and former spouses to enroll under the requested plan. (Those who signed up for a Health Maintenance Organization (HMO) are not eligible.)
- Receive the initialed SF 2809 from the enrollee and ensure that the information is accurate, complete, and signed by both the enrollee and an Agency official.
- Complete the Agency or Retirement System portion of the SF 2809 (Part I), by identifying the Public Law covering the enrollee (either P.L. 98-615 - Civil Service Retirement Spouse Equity Act of 1984 (Law 1) or P.L. 100-654 - Temporary Continuation - 5 USC 8905a or P.L. 102-484 National Defense Authorization Act for Fiscal Year 1993) along with their submitting office number, date of qualifying event, and additional information regarding the original employee.
- Return the enrollee's copy of the SF 2809 and/or SF 2810 to the enrollee, keep the new carrier copy for its records, and establish enrollee in DPRW. Prepare the SF 2810 and attach the initialed SF 2809 with the additional enrollment information required for the transfer of Spouse Equity Act enrollees to NFC.



- Enter all new enrollments, SF 2809 and/or SF 2810 in DPRW.
- Respond to inquiries from NFC personnel relating to the initial SF 2809 and data submitted for new enrollees.
- Verify printed SF 2809 (if prior to June 1988), then include enrollee and Agency telephone numbers and effective date of Other Insurance.
- Review the monthly report DPRS 1501 to ensure that all SF 2809s submitted by their office have been processed correctly.
- Forward semi-monthly report DPRS 1601 to the retirement section of the Agency payroll office.
- Before the registration has been certified in DPRW, enter any corrections to the initial SF 2809 or SF 2810 as a result of an administrative error.
- Explain to the enrollee that they must pay the total cost of the coverage (their share and the amount the Government normally contributes for the employee, P.L. 100-654).
- Advise the enrollee to plan for any normal medical needs (especially with HMOs). There could be a delay of 30-45 days before an enrollee is established on the carrier's system. NFC sends information to the carriers every Wednesday. It takes the carriers at least 2 weeks after receipt to establish the enrollee into the applicable plan. Also, NFC will bill the enrollee on the first of the month following the latter of the effective date of coverage or the date established in our system.

Office of Personnel Management (OPM) Responsibilities

Below are the responsibilities of OPM.

OPM will:

- Determine eligibility of retirees and survivors eligible under P.L. 101-303, Direct Pay Annuitant/Survivors.
- Complete the Agency or Retirement System portion of the SF 2809/SF 2810 identifying the public law covering the enrollee.
- Return the enrollees copy of the SF 2809/SF 2810 to the enrollee and establish the enrollment or transfer-in in the DPRW enrollment portal.

National Finance Center (NFC) Responsibilities

Below are the responsibilities of NFC.

NFC will:

- Maintain enrollee accounts.



- Respond to billing and collections inquiries.
- Process subsequent changes in enrollment for all categories of enrollees.
- Handle open season processing.
- Coordinate the transfer of Temporary Continuation of Coverage (TCC) and Spouse Equity enrollees.
- Determine the eligibility for reinstatement of an enrollee maintained by DPRS.
- Provide enrollees with correspondence relating to their enrollment in DPRS after their initial enrollment.



System Access to DPRW

This section provides access security information and gives specific login/log-out instructions.

This section includes the following topics:

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Security Access

To access DPRW, you must (1) have authorized security clearance and (2) use a computer that is connected to the Internet. Agencies must request access to this application through their Agency's NFC security officer.

Authorized Roles are as follows:

- HR
- OPM
- NFC Operations
- Auditor - read only

Login to DPRW

Individuals who are eligible for extended FEHB coverage under P.L. 98-615, P.L. 100-654, P.L. 102-484, or P.L. 101-303 apply for initial enrollment by providing their Agency submitting offices with a completed SF 2809, see **SF 2809, Health Benefits Election Form** (on page 70) and **Appendix II, Instructions on Completing the SF 2809** (on page 88). For examples of completed SF 2809s, see **SF 2809, Types of New Enrollments** (on page 75).



To establish enrollments into DPRW, the following steps are required.

To Login to DPRW:

1. Connect to the *NFC Home Page* (<http://www.nfc.usda.gov>).
2. Go to the MyNFC drop-down menu. Select Insurance Services Clients.
3. Click the DPRW icon on the Launch an Insurance Application. The DPRW Warning page is displayed.

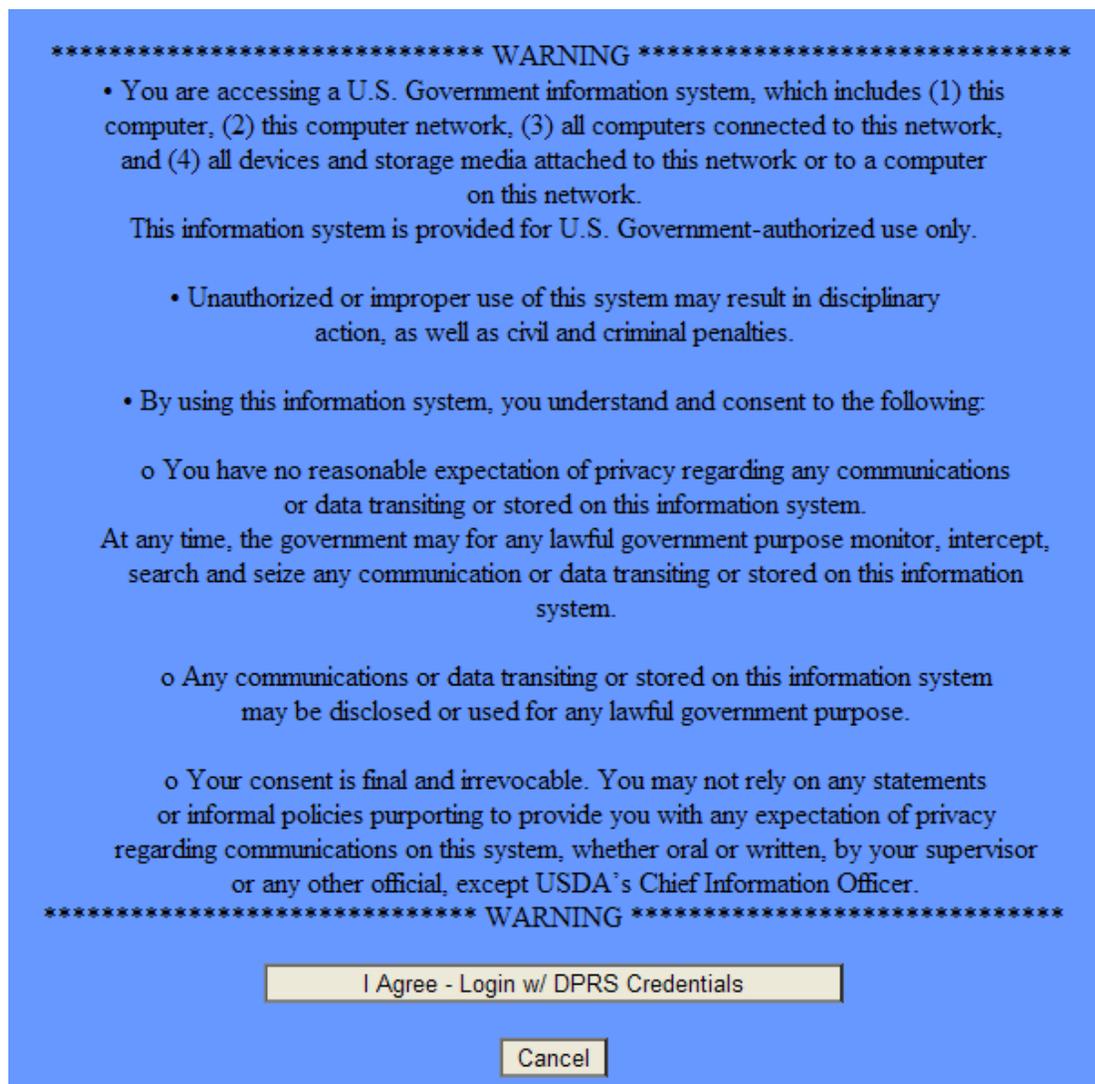


Figure 1: DPRS Warning Page

4. Read the warning and click **I Agree - Login w/DPRS Credentials**. The DPRS Login page is displayed.



OR

Click **Cancel** to return to the Internet.

Direct Premium Remittance System (DPRS)

User ID

Password

Change Password

Login

Figure 2: Direct Premium Remittance System (DPRS) Login Page

5. Complete the fields as follows:

Field	Description/Instruction
User ID	Type your DPRS user identification (ID).
Password	Type your DPRS password.



6. Click **Login**. The FEHB DPRS program page is displayed.

HOME DPRS REPORTSLOGOUT

Direct Premium Remittance System (DPRS)



DPRS allow certain individuals who are not Federal employees are eligible to participate in the FEHB Program under Public Law (P.L.) as described below.

- P.L. 98-615 (5 USC 8905a), Civil Service Retirement Spouse Equity Act of 1984, provides for the enrollment of certain former spouses of current, retired, or separated Federal employees in FEHB.
- Title II of P.L. 100-654 (5 USC 8905a), Federal Employees Health Benefits Amendments Act of 1988, provides for temporary continuation of coverage under FEHB for (1) certain individuals who separate from Federal service, (2) children (of Federal employees, annuitants, or separated employees already enrolled in FEHB) who lose their status as family members, and (3) certain former spouses of current or separated Federal employees or annuitants who would otherwise not be eligible for continued FEHB coverage.
- P.L. 101-303 (5 USC 8906I), Direct Pay Annuitant/Survivors, provides for annuitants/survivors to pay health benefit premiums directly to NFC when the annuity is insufficient to pay the withholdings for the plan that the annuitant/survivor is enrolled. P.L. 102-484, National Defense Authorization Act for Fiscal Year 1993, amends the temporary continuation of coverage under FEHB for certain civilian employees of the Department of Defense separated under a reduction-in-force.
- P.L. 104-106, National Defense Authorization Act for Fiscal Year 1996, amends the temporary continuation of coverage under FEHB to cover employees who voluntarily separate from surplus positions.

Contact	Phone	Email
DPRS Operations	(800) 242-9630	nfc.dprs@nfc.usda.gov
Kathy Roussel	(504) 426-1342	kathleen.roussel@nfc.usda.gov
Robert Nobles	(504) 426-1310	robert.nobles@nfc.usda.gov
Yolanda Bienemy	(504) 426-1315	yolanda.bienemy@nfc.usda.gov

OK



Figure 3: Direct Premium Remittance System (DPRS) FEHB Program Page

7. Select **DPRS** tab.

OR

Click **OK**. This will automatically bring you to the DPRS Menu page.

DPRW consists of three page tabs: **HOME**, **DPRS**, and **REPORTS**.

- The **HOME** page contains applicable laws, guidance, and contact information.
- The **DPRS** page is used to add new enrollments, search and complete existing enrollments, and correct enrollments that have not been processed in the nightly batch job or to view certified records that have been processed to the DPRS mainframe.
- The **REPORTS** page displays links to DPRS reports.

Change Password

To Change Your Password:

1. At the Login to DPRS, enter your user ID and password.

Direct Premium Remittance System (DPRS)

User ID

Password

Change Password

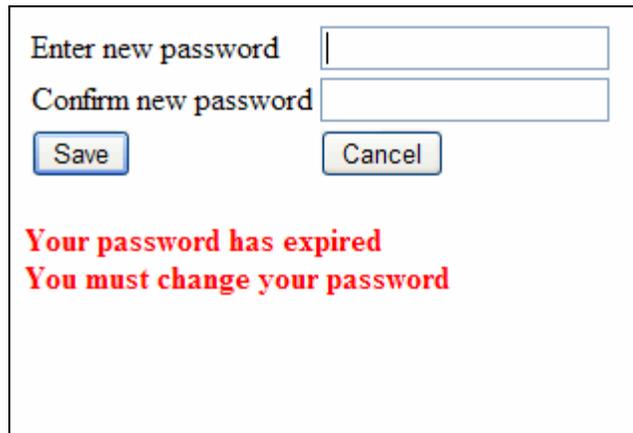
Login

Figure 4: Direct Premium Remittance System (DPRS) Login Page

2. Click **Change Password**. You may change your password at any time.



3. Click **Login**. The fields necessary to change your password will display.



Enter new password

Confirm new password

**Your password has expired
You must change your password**

Figure 5: Change Password Page

4. Complete the fields as follows to change a password:

Field	Instruction
Enter new password	Type your new password. Your password is not displayed on the page. Press Tab .
Confirm new password	Retype your new password to verify the password that you entered in the Enter new password field. Your password is not displayed on the page. Validate the entry for correctness.

5. Click **Save**.

Once saved is pressed, the Password Changed popup appears as confirmation that your *password successfully updated*.

OR

If password does not match, an error message will appear *Password and Confirmation do not match*.

Existing DPRW

On any DPRW page, click **LOGOUT**. The log-out page is displayed with the message *You have successfully logged out of Direct Premium Remittance System. For security reasons this browser window will automatically close*.

Note: Any unsaved changes will be lost.



DPRS Menu

The DPRS Menu generates new enrollees, searches/completes a new enrollee's registration, and makes corrections to a new enrollee's registration before the enrollment is processed or generated.

To establish new enrollments into DPRS, the following steps are required.

Figure 6: DPRS Menu Page

1. Enter the Social Security number (SSN).
2. Click one of the following buttons.

Button	Description/Instruction
Add Registration SF2809	New enrollees - establish enrollment of a child of a current employee, enrollment of a separated employee, and initial enrollment of former spouse of current employee.
Search/Complete Registration SF2809	Search/complete a new enrollee's registration.
Correct Registration SF2809	Make corrections to a new enrollee's registration before the enrollment is processed or generated.
View Certified SF2809	View display of new enrollments that have been certified and processed in the nightly batch job. <u>Note: This is an NFC Operations function only.</u>



OR

If the enrollee has been certified and is in the DPRS mainframe, enter the enrollee's last name.

The screenshot shows the DPRS Menu page with a blue header and navigation tabs for HOME, DPRS, and REPORTS. A LOGOUT link is in the top right. The main content area is titled 'DPRS Menu' and contains two sections for user input. The first section, 'Enter a Social Security Number and choose a button.', includes a text field for 'Social Security Number' and three buttons: 'Add Registration SF2809', 'Search/Complete Registration SF2809', and 'Correct Registration SF2809'. Below this is a 'View Certified SF2809' button. The second section, 'Enter a Name and choose Search Name button.', includes text fields for 'First Name', 'Middle Initial', and 'Last Name *' (with 'MARKS' entered). A 'Search Name' button is below these fields. At the bottom, a table displays search results for the name 'MARKS'.

Action	First Name	Middle Initial	Last Name	SSN	Birthday	Address	Address2	City	State	Zip
Search/Complete	TRAINER		MARKS	XXXXXXXXXX	XXXXXXXXXX12:00:00 AM	XXX LUNDENWOOD LN		NORTHBROOK	IL	

Figure 7: DPRS Menu Page (Search Name)

3. Click **Search Name**. A name or list of names is returned from the DPRS mainframe for the user to select. Each unique record (First Name, Middle Initial, Last Name, SSN, Birthday, Address, City, State, and ZIP Code) for the enrollee will be displayed.
4. Click **Search/Complete** to update/complete the enrollee's information. If the enrollee has been certified, a message will appear, *SSN Certified on Mainframe. Contact DPRS Operation, at 800-242-9630 or Email DPRS Operation*
<https://www.nfc.usda.gov/ClientServices/Insurance/services/dprs/contact.php> for changes.

OR

Click **Correct** to updated any information on the enrollee's initial enrollment. If the enrollee has been certified, a message will appear, *SSN Certified on Mainframe. Contact DPRS Operation, at 800-242-9630 or Email DPRS Operation*
<https://www.nfc.usda.gov/ClientServices/Insurance/services/dprs/contact.php> for changes.

OR

Click **View** to review the initial enrollment information. If the enrollee has been certified, a message will appear, *SSN Certified on Mainframe. Contact DPRS Operation, at 800-242-9630 or Email DPRS Operation*
<https://www.nfc.usda.gov/ClientServices/Insurance/services/dprs/contact.php> for changes.



Inquiries

This section explains the responsibilities of the primary organizations on all questions regarding eligibility and accounts.

This section includes the following topics:

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Agency Inquiries

Agency submitting offices:

Questions relating to the eligibility of separated employees and former spouses/children of current employees will be handled by the submitting office.

National Finance Center (NFC) Inquiries

NFC:

All questions from enrollees and/or their Agencies regarding their accounts should be referred to and will be handled by NFC.

NFC may refer a question/problem to the HR Office of the employing Agency for final ruling or clarification through the appropriate channel to OPM.

NFC has established a toll free telephone inquiry line for DPRS enrollees. The number is **1-800-242-9630**. The line is available from 7:45 a.m. to 4:00 p.m., central time, Monday through Friday (except Federal holidays).

OPM Inquiries

OPM:

All questions related to retirement processing or changes prior to the transfer-in date of an annuitant/survivor will be handled by OPM's Insurance and Retirement Group.



Establish Enrollment

Individuals who are eligible for extended FEHB coverage under the P.L. 98-615, P.L. 100-654, P.L. 102-484, or P.L. 101-303 will apply for initial enrollment by providing their Agency submitting offices with a completed SF 2809, Health Benefits Registration form. The Federal Agencies will enroll the eligible non-Federally employed individuals in DPRS.

This section includes the following topics:

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Forms That are Required for DPRS

This section includes the following forms:

SF 2809, Employee Health Benefits Election Form.

When to establish an SF 2809:

- Enroll or re-enroll in the FEHB Program,
- Elect not to enroll in the FEHB Program (*employee only*),
- Change your FEHB enrollment,
- Cancel your FEHB enrollment, and
- Suspend your FEHB enrollment (*annuitants or former spouses only*).

SF 2810, Notice of Change in Health Benefits Enrollment.

When to establish an SF 2810:

- Termination:
 - 31-Day Extension of Coverage,
 - Conversion to Nongroup Contract,
 - Time Limited on Conversion,
 - Temporary Continuation of Coverage, and
 - Entry on Active Military Duty.



- Transfer:
 - Transfer of Employment,
 - Retirement,
 - Death, and
 - Employees' Compensation.

Who May Use an SF 2809

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

Note: CSRS and FERS annuitants and former spouses and children of CSRS/FERS annuitants - **do not use this form**. Instead, use OPM 2809, Health Benefits Registration Form (only for use by Annuitants and Former Spouses of Annuitants), which is available at www.opm.gov/retire, or call the Retirement Information Office toll free at **1-888-767-6738**.

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 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 the Spouse Equity law or similar statutes.

New Enrollment Requirements

To Establish a New Enrollment

Agencies	Advise eligible individuals of coverage available under P.L. 98-615 and P.L. 100-654.
Eligible Enrollees	Prepare an SF 2809 and forward to Agency.
Agencies	Complete an SF 2809 and establish enrollee into DPRW for a DPRS enrollment.



NFC	Generate an SF 2809 copy to FEHB carrier. Forward enrollee coupon book for making payments through lock box. Monitor enrollee accounts. Provide reporting to OPM and carrier.
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Before entering into the DPRW system, the Agency must enter the following information on the SF 2809:

- Effective date of the enrollment.
- Enrollment code.
- Submitting Office Number (SON). The document will fail processing if the SON is missing or incorrect and enrollment of the applicant may be delayed.
- The following information must be included in the Remarks block in exactly the order shown, as appropriate for the class of the enrollee:

Separated employee:

- Relationship (self).
- P.L. under which the applicant is eligible using the law's whole number (i.e., P.L. 100-654 (5 U.S.C. 8905a)).
- Date of separation.
- Last day of pay period.

Former spouse and child of a current employee:

- Relationship (ex-spouse, child).
- P.L. under which the applicant is eligible for benefits, using the law's whole number (e.g., P.L. 98-615 or P.L. 100-654 (5 U.S.C. 8905a)).
- Name of the employee.
- SSN of the employee.
- Date of birth (DOB) for the employee.
- Date of the qualifying event (e.g., divorce, annulment, date of 22nd birthday, P.L. 100-654 enrollees only).

Former spouse and child of a separated employee:

- Persons in this category should contact NFC directly for enrollment information.

Former spouse and child of CSRS, FERS, or other retirement systems' annuitants:



- OPM will continue to process all accounts for their annuitants' children or former spouses. Forms for these individuals should be sent to OPM, not to NFC.
- The original employee/former employee information will be needed to establish a DPRS enrollee master, to determine the enrollment expiration date in the case of P.L 100-654 enrollees, and to provide this information to the carrier.
- After all information is complete, the submitting office should return the enrollee's copy to the enrollee and keep the new carrier copy for the records.

Upon receipt of the initial SF 2809 for enrollment into a plan, NFC will generate a copy of the SF 2809 to the carrier and establish an enrollee master in the DPRS database.

DPRS Transaction Batch Codes

DPRS Transaction Batch codes:

- **AW01** - New Enrollment
- **BW01** - Transfer-In Enrollment
- **CW04** - Change/correct original enrollee and/or dependent (sex, SSN, marital status, other insurance, and family)
- **DW03** - Change/correct original enrollee and/or dependent (name, date of birth, address, Department of Defense (DOD) component, activity, location, domestic address indicator, phone number, State, ZIP Code, country code, and SON).



New Enrollments in DPRW

DPRW will enable HR Agencies and OPM to enter the new enrollments into DPRS through the Web interface. Once the online SF 2809s and SF 2810s are certified to be sent to NFC, they are picked up and processed in a nightly batch processing. The data is validated and submitted to the DPRS mainframe system. After the nightly processing, either a new enrollment record or a suspense record is created in DPRS. NFC Operations reviews and clears all suspense in DPRS.

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Enrollment Records

There are four parts to an enrollment record in DPRW.

Enrollment Records	Description
Part A	This page contains the overall enrollee information. The required fields on this page must be completed before the record can be saved.
Family Information	As a supplemental page to Part A, this page contains the dependent information.
Part B	This page displays different fields based on the Public Law selected on Part A. It contains information on the event that enables the enrollment.
Part C	This page contains the information on the processing of the action including the processing office and effective date of the enrollment.

New Enrollee SF 2809 Part A

The SF 2809 Part A is used to establish enrollment of a child of a current employee, enrollment of a separated employee, or initial enrollment of former spouse of current employee. The following steps are required:

1. On the DPRS Main Menu, enter the enrollee's SSN.



2. Click **Add Registration SF 2809**.

Figure 8: DPRS Menu Page

3. The SF 2809 Part A page is displayed.

Figure 9: SF2809 Part A Page

4. Complete Part A - Enrollee Information fields as follows:

Note: Required fields are marked with an asterisk.



Field	Description/Instruction
<p>Public Law*</p>	<p>Click the down arrow to display the list and select the correct category. Each category is designated by a number, which identifies the enrollee group.</p> <p>Valid Values are:</p> <p>98-615 Spouse Equity</p> <p>100-654 Temporary Continuation of Coverage (TCC)</p> <p>102-484 Dept of Defense (DOD) Reduction in Force System (RIF)</p> <p>101-303 Annuitants</p> <p>111-5 ACA</p> <p>Note: For guidelines on the laws to which the Agency can process each law, refer to Appendix I, Public Laws Guidelines (on page 87).</p>
<p>Relationship To Employee*</p>	<p>Click the down arrow to display the list and select the relationship of the eligible separated employee.</p> <p>Valid Values are:</p> <p>Self</p> <p>Former Spouse</p> <p>Child</p>
<p>Current Enrollment Plan</p>	<p>Enter the enrollment plan that the enrollee is currently enrolled in.</p>
<p>New Enrollment Plan*</p>	<p>Enter the enrollment plan code requested by the enrollee.</p>
<p>First Name*</p>	<p>Enter the Federal employee's/annuitant's first name. If the employee has two or more first names or initials (e.g., John Paul or JP) and each is to be shown, use a space to separate the two names. Do not include titles, such as Mr., Mrs., Ms., Dr., or Prof., as part of the name.</p> <hr/> <p>Note: This field is limited to 15 characters.</p>
<p>Middle Initial</p>	<p>Enter the Federal employee's/annuitant's middle initial. If the employee has two or more middle names or initials (e.g., Ann Marie or AM) and each is to be shown, use a space to separate the two names or initials. Leave the middle name blank if the employee has no middle name or initial.</p>



Field	Description/Instruction
Last Name*	<p>Enter the Federal employee's/annuitant's last name. Enter items such as Jr., Sr., or III, with one space after the last name. If more than one space is entered, the additional item will not print on the SF 50B, Notice of Personnel Action.</p> <p>If the employee has a two-part last name (i.e., Smith Martin), use a space to separate the two parts.</p> <p>Do not use any type of punctuation (e.g., hyphen, period, etc.) in any part of the name.</p> <p>A space counts as one character. For long names, ask the employee to provide an abbreviation.</p> <hr/> <p>Note: This field is limited to 20 characters.</p>
Social Security Number*	<p>Enter the Federal employee's/annuitant's SSN. When entering an SSN, type the nine numeric digits. Do not type dashes or hyphens.</p>
Date of Birth*	<p>Click the calendar icon for the Federal employee's/annuitant's date of birth. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
Sex*	<p>Click the down arrow to display the list and select the appropriate sex.</p> <p>Valid Values are:</p> <p>Male Female</p>
Married*	<p>Click the down arrow to select the initial status.</p> <p>Valid Values are:</p> <p>Yes No</p> <hr/> <p>Note: If the enrollee is separated but not divorced, they are still married.</p>
Country	<p>Defaults to United States. For a different country, click the down arrow to display the list and select the appropriate country.</p>



Field	Description/Instruction
Domestic	Defaults to Yes . If not domestic, click the down arrow to display the list and select No . Valid Values are: Yes - Default No
Address 1*	Enter the enrollee's residence address, number, and street name of where the enrollee resides.
Address 2	Enter an additional address if the enrollee receives information related to the request for action.
City*	Enter the name of the city of the enrollee's residence address.
State*	Click the down arrow to display the list and select the appropriate State.
Zip*	Enter the five-digit ZIP Code of the enrollee's address.
Home Phone*	Enter the telephone number beginning with the area code for the individual to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.
Work Phone	Enter the telephone number beginning with the area code for the individual to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.
Cell Phone	Enter the telephone number beginning with the area code for the individual to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.
Email	Enter the email address for the individual to be contacted for information related to the request for action. <hr/> Note: This field is optional. If an email address is provided, the email address must be entered in DPRW.



Field	Description/Instruction
Other Insurance	<p>Defaults to None. If the enrollee has other insurance, click the down arrow to display the list and select the appropriate type.</p> <p>Valid Values are:</p> <p>None - Default Medicare A Medicare B Medicare D Tricare FEHB Other</p> <hr/> <p>Note: If the enrollee has Medicare, check which part including prescription drug coverage under Medicare Part D.</p>
Medicare Claim Number	<p>If Medicare has been selected, the Medicare Claim Number must be entered in this field.</p> <hr/> <p>Note: The claim number can be found on the enrollee's Medicare card.</p>
Other Insurance Name	<p>If covered by other health insurance (either the enrollee's name or under a family member's policy), enter the insurance name.</p>
Insurance Policy Number	<p>If another health insurance has been listed, the health insurance policy number must be entered in the field.</p> <hr/> <p>Note: The policy number can be found on the enrollee's health insurance card.</p>
SON Number*	<p>Click the down arrow to display the list and select the appropriate SON.</p> <hr/> <p>Note: Select the enrollee's submitting office number.</p>

5. After completing the fields, click **Save SF2809**.

OR

Click another part or link of the enrollment pages, and the record will automatically be saved.

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.



New Enrollee SF 2809 Part A Family Information

To establish enrollment for a family policy, the following steps are required:

1. On the SF 2809 Part A page, select **Family Info** to enter the dependent information. The SF 2809 Part A Family Information page is displayed.

Figure 10: SF2809 Part A, Family Information Page

2. Complete SF 2809 Part A, Enrollee Information fields as follows:

Field	Description/Instruction
First Name	Enter the Federal employee's/annuitant's first name. If the employee has two or more first names or initials (e.g., John Paul or JP) and each is to be shown, use a space to separate the two names. Do not include titles, such as Mr., Mrs., Ms., Dr., or Prof., as part of the name. <u>Note: This field is limited to 15 characters.</u>
Middle Initial	Enter the Federal employee's/annuitant's middle initial. If the employee has two or more middle names or initials (e.g., Ann Marie or AM) and each is to be shown, use a space to separate the two names or initials. Leave the middle name blank if the employee has no middle name or initial.



Field	Description/Instruction
Last Name	<p>Enter the Federal employee's/annuitant's last name. Enter items such as Jr., Sr., or III, with one space after the last name. If more than one space is entered, the additional item will not print on the SF 50B.</p> <p>If the employee has a two-part last name (i.e., Smith Martin), use a space to separate the two parts.</p> <p>Do not use any type of punctuation (e.g., hyphen, period, etc.) in any part of the name.</p> <p>A space counts as one character. For long names, ask the employee to provide an abbreviation.</p> <hr/> <p><u>Note: This field is limited to 20 characters.</u></p>
Social Security Number	<p>Enter the Federal employee's/annuitant's SSN. When entering an SSN, type the nine numeric digits. Do not type dashes or hyphens.</p>
Date of Birth	<p>Click the calendar icon for the Federal employee's/annuitant's date of birth. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p><u>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</u></p>
Sex	<p>Click the down arrow to display the list and select the appropriate sex.</p> <p>Valid Values are:</p> <p>Male Female</p>
Relationship	<p>Click the down arrow to display the list and select the relationship of the eligible separated employee.</p> <p>Valid Values are:</p> <p>Self Former Spouse Child</p>
Country	<p>Defaults to United States. For a different country click the down arrow to display the list and select the appropriate country.</p>



Field	Description/Instruction
Domestic	Defaults to Yes . If not domestic, click the down arrow to display the list and select No . Valid Values are: Yes - Default No
Address 1	Enter the enrollee's residence address, number, and street name of where the enrollee resides.
Address 2	Enter an additional address if the enrollee receives information related to the request for action.
City	Enter the name of the city of the enrollee's residence address.
State	Click the down arrow to display the list and select the appropriate State.
Zip	Enter the five-digit ZIP Code of the enrollee's address.
Home Phone	Enter the telephone number beginning with the area code for the individual to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.
Work Phone	Enter the telephone number beginning with the area code for the individual to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.
Cell Phone	Enter the telephone number beginning with the area code for the individual to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.
Email	Enter the email address for the individual to be contacted for information related to the request for action. <hr/> Note: This field is optional. If an email address is provided, the email address must be entered in DPRW.



Field	Description/Instruction
Other Insurance	<p>Defaults to None. If the enrollee has other insurance, click the down arrow to display the list and select the appropriate type.</p> <p>Valid Values are:</p> <p>None - Default Medicare A Medicare B Medicare D Tricare FEHB Other</p> <hr/> <p>Note: If the enrollee has Medicare, check which part including prescription drug coverage under Medicare Part D.</p>
Medicare Claim Number	<p>If Medicare has been selected, the Medicare Claim Number must be entered in this field.</p> <hr/> <p>Note: The claim number can be found on the enrollee's Medicare card.</p>
Other Insurance Name	<p>If covered by other health insurance (either the enrollee's name or under a family member's policy), enter the insurance name.</p>
Insurance Policy Number	<p>If another health insurance has been listed, the health insurance policy number must be entered in the field.</p> <hr/> <p>Note: The policy number can be found on the enrollee's health insurance card.</p>

3. Click **Add Family**.
4. Once the required fields are completed, click **Save SF2809**.

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

5. To make a change to a family member, select the family member, click **Edit**.
6. Update the required fields.



7. Click **Update Family**.

Action	Enrollee SEQ	Family Member SEQ	First Name	Middle Initial	Last Name	SSN	Birthday	Sex	Relationship	Address	Address2	City	State	Zip	Zip4	Domestic Indicator
Edit Delete	2654	1844	jessica	c	smith	XXXXXXXXXX	09-02-1990	F	01	308 dog rd		city	state	XXXXXX		Y
Edit Delete	2654	1845	austin	c	smith	XXXXXXXXXX	11-12-1988	M	19	308 dog rd		city	state	XXXXXX		Y

Figure 11: SF2809 Part A, Family Information Page

8. Once the dependent is added, the dependent information will display at the bottom of the page. Edit or delete the dependent's information using the Action buttons.

Button	Instruction
Edit	Click the edit button, the current information will populate in the Family Information page. Update the information in the fields as needed and click Update Family .
Delete	Click the delete button next to the appropriate dependent. To confirm the deletion, click OK .

9. To add more family members, click **Add Family**.

OR

If no additional information is needed, click **Save SF2809** to continue to Part B.



10. To clear the family information fields for unsaved changes, click **Reset Family**.

New Enrollee SF 2809 Part B

The SF 2809 Part B page is used to document the event and date details that enable the participant to enroll. This is a continuation from SF 2809 Part A page for the enrollment. The following pages display different fields based on the Public Law selected on Part A.

For more information see:

Public Law, Temporary Continuation of Coverage (TCC)	34
Public Law, TCC, Former Spouse and Child	36
Public Law, Spouse Equity	39
Public Law, Department of Defense separated under the Reduction in Force (DOD-RIF)	41
Public Law, Annuitants	43
Public Law, Annuitants - Surviving Spouse or Child(ren)	45
Public Law, Affordable Care Act (ACA)	48

Public Law, Temporary Continuation of Coverage (TCC)

On any of the SF 2809 pages, select **Part B** to complete the enrollment for registration. The SF 2809 Part B page is displayed base on **Public Law TCC - Self**.

Figure 12: SF2809 Part B Page, TCC Public Law - Self

1. Complete SF 2809 Part B - Self fields as follows:



Field	Description/Instruction
Event Code	Populates based on the Public Law selected on Part A.
Event Date	<p>Click the calendar icon for the date that the enrollee signed the SF 2809. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
Separation Date	<p>Click the calendar icon for the date that the Federal employee was separated. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
Last Date of Pay Period	<p>Click the calendar icon for the last day of the pay period the enrollee's separation date descended in. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
Signature Date*	<p>Click the calendar icon for the date that the enrollee signed the SF 2809. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
REMARKS	Enter any additional information.

2. After completing the fields, click **Save**.

OR

Click one of the four parts of the enrollment pages, and the record will automatically be saved.



Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

Public Law, TCC, Former Spouse and Child

On any of the SF 2809 pages, select **Part B** to complete the enrollment for registration. The SF 2809 Part B page is displayed base on **Public Law TCC - Former Spouse and Child**.

Figure 13: SF2809 Part B Page, TCC Public Law - Former Spouse and Child

1. Complete SF 2809 Part B - Former Spouse and Child fields as follows:

Note: Required fields are marked with an asterisk.

Field	Description/Instruction
Event Code	Populates based on the Public Law selected on Part A.



<p>Action Effective Date</p>	<p>Click the calendar icon for the date which the enrollment will be effective. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
<p>Separation/Event Date</p>	<p>Click the calendar icon for the Federal employee's/annuitant's separation/event date of the enrollee. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
<p>Signature Date*</p>	<p>Click the calendar icon for the date that the enrollee signed the SF 2809. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
<p>SSN</p>	<p>Enter the Federal employee's/annuitant's SSN. When entering an SSN, type the nine numeric digits. Do not type dashes or hyphens</p>
<p>DOB</p>	<p>Click the calendar icon for the Federal employee's/annuitant's date of birth. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
<p>First Name</p>	<p>Enter the Federal employee's/annuitant's first name. If the employee has two or more first names or initials (e.g., John Paul or JP) and each is to be shown, use a space to separate the two names. Do not include titles, such as Mr., Mrs., Ms., Dr., or Prof., as part of the name.</p> <hr/> <p>Note: This field is limited to 15 characters.</p>
<p>Middle Initial</p>	<p>Enter the Federal employee's/annuitant's middle initial. If the employee has two or more middle names or initials (e.g., Ann Marie or AM) and each is to be shown, use a space to separate the two names or initials. Leave the middle name blank if the employee has no middle name or initial.</p>



Last Name	<p>Enter the Federal employee's/annuitant's last name. Enter items such as Jr., Sr., or III, with one space after the last name. If more than one space is entered, the additional item will not print on the SF 50B.</p> <p>If the employee has a two-part last name (i.e., Smith Martin), use a space to separate the two parts.</p> <p>Do not use any type of punctuation (e.g., hyphen, period, etc.) in any part of the name.</p> <p>A space counts as one character. For long names, ask the employee to provide an abbreviation.</p> <hr/> <p>Note: This field is limited to 20 characters.</p>
Account Type	<p>For survivor annuitants, select the appropriate value.</p> <ul style="list-style-type: none">• Annuitant• Surviving Spouse• Surviving Spouses/Child(ren)• Surviving Child(ren)• Disabled Child(ren) <hr/> <p>Note: If the Account Type is for Surviving Spouse, Surviving Spouse/Child(ren), Surviving Child(ren), or Disabled Child(ren) additional fields will display to enter in the Federal employee's/annuitant's information.</p>
Claim Number	Type in the OPM-provided claim number beginning with an A or F.
REMARKS	Enter any additional information.

2. After completing the fields, click **Save**.

OR

Click one of the four parts of the enrollment pages, and the record will automatically be saved.

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.



Public Law, Spouse Equity

On any of the SF 2809 pages, select **Part B** to complete the enrollment for registration. The SF 2809 Part B page is displayed base on **Public Law, Spouse Equity**.

Figure 14: SF2809 Part B Page, Spouse Equity Public Law

1. Complete SF 2809 Part B - Spouse Equity fields as follows:

Note: Required fields are marked with an asterisk.

Field	Description/Instruction
Event Code	Populates based on the Public Law selected on Part A.
Signature Date*	Click the calendar icon for the date that the enrollee signed the SF 2809. Each down arrow displays a list; select the correct year, month, and date. Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.
SSN	Enter the Federal employee's/annuitant's SSN. When entering an SSN, type the nine numeric digits. Do not type dashes or hyphens.



DOB	<p>Click the calendar icon for the Federal employee's/annuitant's date of birth. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
First Name	<p>Enter the Federal employee's/annuitant's first name. If the employee has two or more first names or initials (e.g., John Paul or JP) and each is to be shown, use a space to separate the two names. Do not include titles, such as Mr., Mrs., Ms., Dr., or Prof., as part of the name.</p> <hr/> <p>Note: This field is limited to 15 characters.</p>
Middle Initial	<p>Enter the Federal employee's/annuitant's middle initial. If the employee has two or more middle names or initials (e.g., Ann Marie or AM) and each is to be shown, use a space to separate the two names or initials. Leave the middle name blank if the employee has no middle name or initial.</p>
Last Name	<p>Enter the Federal employee's/annuitant's last name. Enter items such as Jr., Sr., or III, with one space after the last name. If more than one space is entered, the additional item will not print on the SF 50B.</p> <p>If the employee has a two-part last name (i.e., Smith Martin), use a space to separate the two parts.</p> <p>Do not use any type of punctuation (e.g., hyphen, period, etc.) in any part of the name.</p> <p>A space counts as one character. For long names, ask the employee to provide an abbreviation.</p> <hr/> <p>Note: This field is limited to 20 characters.</p>
REMARKS	<p>Enter any additional information.</p>

2. After completing the fields, click **Save**.

OR

Click one of the four parts of the enrollment pages, and the record will automatically be saved.

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.



Public Law, Department of Defense separated under the Reduction in Force (DOD-RIF)

On any of the SF 2809 pages, select **Part B** to complete the enrollment for registration. The SF 2809 Part B page is displayed base on **Public Law, DOD-RIF**.

Figure 15: SF2809 Part B Page, DOD-RIF Public Law

1. Complete SF 2809 Part B - DOD-RIF fields as follows:

Field	Description/Instruction
Event Code	Populates based on the Public Law selected on Part A.
Event Date	Click the calendar icon for the date that the enrollee signed the SF 2809. Each down arrow displays a list; select the correct year, month, and date. Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.
Separation Date	Click the calendar icon for the Federal employee's/annuitant's separation date of the enrollee. Each down arrow displays a list; select the correct year, month, and date. Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.



Field	Description/Instruction
Last Date of Pay Period	<p>Click the calendar icon for the last day of the pay period the enrollee's separation date descended in. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
Signature Date*	<p>Click the calendar icon for the date that the enrollee completed the form. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
Number Hours (DOD Only)	Verify the number of hours for the employee's tour of duty. This field defaults to 080.
DOD Component	Enter the component within DOD for which the Federal employee worked.
DOD Activity	Enter the specific activity for which the Federal employee worked.
DOD Location	Enter the numeric location.
REMARKS	Enter any additional information.

2. After completing the fields, click **Save**.

OR

Click one of the four parts of the enrollment pages, and the record will automatically be saved.

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.



Public Law, Annuitants

On any of the SF 2809 pages, select **Part B** to complete the enrollment for registration. The SF 2809 Part B page is displayed base on **Public Law, Annuitant**.

Figure 16: SF2809 Part B Page, Annuitant Public Law

1. Complete SF 2809 Part B - Annuitants fields as follows:

Note: Required fields are marked with an asterisk.

Field	Description/Instruction
Event Code	Populates based on the Public Law selected on Part A.
Action Effective Date	Click the calendar icon for the date the enrollment will be effective. Each down arrow displays a list; select the correct year, month, and date. Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.



Separation/Event Date	<p>Click the calendar icon for the Federal employee's/annuitant's separation/event date of the enrollee. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
Signature Date*	<p>Click the calendar icon for the date that the enrollee signed the SF 2809. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
Account Type	<p>For survivor annuitants, select the appropriate value.</p> <ul style="list-style-type: none">• Annuitant• Surviving Spouse• Surviving Spouse/Child(ren)• Surviving Child(ren)• Disabled Child(ren) <hr/> <p>Note: If the Account Type is for Surviving Spouse, Surviving Spouse/Child(ren), Surviving Child(ren), or Disabled Child(ren) additional fields will display to enter in the Federal employee's/annuitant's information.</p>
Claim Number	<p>Type in the OPM-provided claim number beginning with an A or F.</p>
REMARKS	<p>Enter any additional information.</p>

2. After completing the fields, click **Save**.

OR

Click one of the four parts of the enrollment pages, and the record will automatically be saved.

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.



Public Law, Annuitants - Surviving Spouse or Child(ren)

On any of the SF 2809 pages, select **Part B** to complete the enrollment for registration. The SF 2809 Part B page is displayed base on **Public Law, Annuitant - Surviving Spouse or Child(ren)**.

Figure 17: SF2809 Part B Page, Annuitant Public Law - Surviving Spouse or Child(ren)

1. Complete SF 2809 Part B - Annuitants - Surviving Spouse or Child(ren) fields as follows:

Field	Description/Instruction
Event Code	Populates based on the Public Law selected on Part A.
Action Effective Date	Click the calendar icon for the date the enrollment will be effective. Each down arrow displays a list; select the correct year, month, and date. Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.



Separation/Event Date	<p>Click the calendar icon for the Federal employee's/annuitant's separation/event date of the enrollee. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p> <hr/>
Signature Date*	<p>Click the calendar icon for the date that the enrollee signed the SF 2809. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p> <hr/>
SSN	<p>Enter the Federal employee's/annuitant's SSN. When entering an SSN, type the nine numeric digits. Do not type dashes or hyphens.</p>
DOB	<p>Click the calendar icon for the Federal employee's/annuitant's date of birth. Each down arrow displays a list; select the correct year, month, and date.</p> <hr/> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p> <hr/>
First Name	<p>Enter the Federal employee's/annuitant's first name. If the employee has two or more first names or initials (e.g., John Paul or JP) and each is to be shown, use a space to separate the two names. Do not include titles, such as Mr., Mrs., Ms., Dr., or Prof., as part of the name.</p> <hr/> <p>Note: This field is limited to 15 characters.</p> <hr/>
Middle Initial	<p>Enter the Federal employee's/annuitant's middle initial. If the employee has two or more middle names or initials (e.g., Ann Marie or AM) and each is to be shown, use a space to separate the two names or initials. Leave the middle name blank if the employee has no middle name or initial.</p>



Last Name	<p>Enter the Federal employee's/annuitant's last name. Enter items such as Jr., Sr., or III, with one space after the last name. If more than one space is entered, the additional item will not print on the SF 50B.</p> <p>If the employee has a two-part last name (i.e., Smith Martin), use a space to separate the two parts.</p> <p>Do not use any type of punctuation (e.g., hyphen, period, etc.) in any part of the name.</p> <p>A space counts as one character. For long names, ask the employee to provide an abbreviation.</p> <hr/> <p>Note: This field is limited to 20 characters.</p>
Account Type	<p>For survivor annuitants, select the appropriate value.</p> <ul style="list-style-type: none"> • Annuitant • Surviving Spouse • Surviving Spouse/Child(ren) • Surviving Child(ren) • Disabled Child(ren) <hr/> <p>Note: If the Account Type is for Surviving Spouse, Surviving Spouse/Child(ren), Surviving Child(ren), or Disabled Child(ren) additional fields will display to enter in the Federal employee's/annuitant's information.</p>
Claim Number	<p>Type in the OPM-provided claim number beginning with an A or F.</p>
REMARKS	<p>Enter any additional information.</p>

2. After completing the fields, click **Save**.

OR

Click one of the four parts of the enrollment pages, and the record will automatically be saved.

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.



Public Law, Affordable Care Act (ACA)

On any of the SF 2809 pages, select **Part B** to complete the enrollment for registration. The SF 2809 Part B page is displayed base on **Public Law, ACA**.

Figure 18: SF2809 Part B Page, ACA Public Law

1. Complete SF 2809 Part B - ACA fields as follows:

Field	Description/Instruction
Event Code	Populates based on the Public Law selected on Part A.
Event Date	Click the calendar icon for the date that the enrollee signed the SF 2809. Each down arrow displays a list; select the correct year, month, and date. <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p> </div>
Separation Date	Click the calendar icon for the Federal employee's/annuitant's separation date of the enrollee. Each down arrow displays a list; select the correct year, month, and date. <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p> </div>



Field	Description/Instruction
Last Date of Pay Period	Click the calendar icon for the last day of the pay period the enrollee's separation date descended in. Each down arrow displays a list; select the correct year, month, and date. <hr/> Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.
Signature Date*	Click the calendar icon for the date that the enrollee signed the SF 2809. Each down arrow displays a list; select the correct year, month, and date. <hr/> Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.
REMARKS	Enter any additional information.

2. After completing the fields, click **Save**.

OR

Click one of the four parts of the enrollment pages, and the record will automatically be saved.

Note: If there are errors upon saving, an error message will appear. A list of the fields that are missing the required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields are completed.

New Enrollee SF 2809 Part C

The SF 2809 Part C page contains information on the payroll and submitting office and certifies the enrollment. An enrollment will not be sent to NFC for processing until it is certified.



1. On any of the SF 2809 pages, select **Part C** to complete the required fields for enrollment. The SF 2809 Part C page is displayed.

Figure 19: SF2809 Part C Page

2. Complete the SF 2809 Part C - Enrollee Information fields as follows:

Note: Required fields are marked with an asterisk.

Field	Description/Instruction
Date Received*	<p>Click the calendar icon to enter the date the Agency received the SF 2809. Each down arrow displays a list; select the correct year, month, and date.</p> <p>Note: Only the calendar icon can be used to enter dates. Must select year and month, then click on calendar date. It is important that you follow the order, otherwise the calendar will automatically go back to the current date.</p>
Effective Date*	Automatically generates the effective date based on the separation and last day of pay period.



Field	Description/Instruction
Personnel Phone Number*	Enter the telephone number beginning with the area code for the Personnel Office to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.
Name of Agency/Retirement System*	Enter the four-position alpha acronym of the Department the individual is stationed with.
Address*	Enter the address of the Department to be contacted for information related to the request for action.
City*	Enter the name of the city the Department is located.
State*	Click the down arrow to display the list and select the appropriate State.
Zip*	Enter the five-digit ZIP Code of the Department's address.
Payroll Office Number*	Enter the telephone number beginning with the area code for the Department to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.
Payroll Contact First Name*	Enter the first name of the Authorized Agency Official. <u>Note: This field is limited to 15 characters.</u>
Payroll Contact Last Name*	Enter the last name of the Authorized Agency Official. <u>Note: This field is limited to 20 characters.</u>
Payroll Phone Number*	Enter the telephone number beginning with the area code for the payroll office to be contacted for information related to the request for action. When entering the telephone number, do not add any dashes or hyphens.

3. After completing the fields, click **Save**.
4. Click **I Certify This SF 2809** when all required fields are completed.

OR

To add another enrollment or SF 2809, click **If you would like to enter another enrollment click here**.

CAUTION: If the record has not been saved or certified, you will receive a warning message requesting to click **Yes** to save or **No** to cancel the action. If you click **Yes**, the record will only be saved, not certified.



When the user has not completed the required fields on Part A and attempts to save the record or navigate to another part or attempts to certify the record, the Certification Failed page will display a list of fields missing from the registration. All errors must be cleared before the record can be saved or certified.

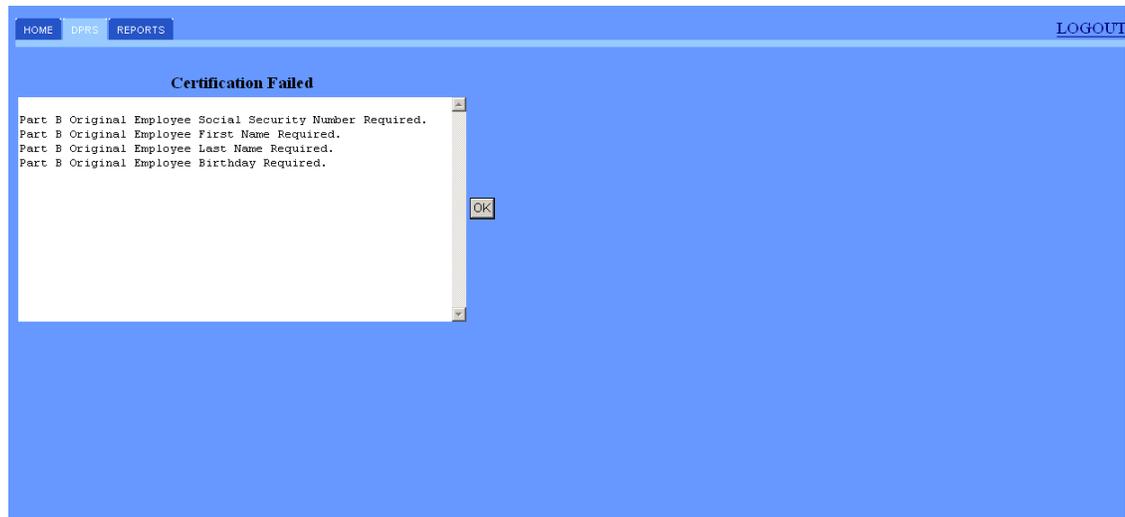


Figure 20: Certification Failed Page

5. Click **OK**. Select the page that is missing the required information to complete the certification.



6. After all required fields are completed, click **I Certify This SF 2809**.

Figure 21: SF2809 Part C Page (Certifying Official)

7. The Certifying Official fields will automatically generate when the registration is certified.

Certifying Official:

Note: Fields listed below will automatically populate when registration is certified.

Field	Description
First Name	First name of the authorized Agency official.
Last Name	Last name of the authorized Agency official.
UserID	Authorized Agency official's user ID that processed the request.
Date of Certification	Date the enrollment was certified.

Note: If there are errors upon saving or certifying, the Certification Failed page will display. A list of the fields which are missing required information will be displayed. If an error occurred upon saving the record, return to Part A and verify that all fields in each part of the enrollment are completed. All errors must be



cleared before the record can be saved or certified. If the record will not process, go to DPRW **HOME**, reenter the SSN, and select **Search/Complete Registration SF 2809** and re-certify the enrollment.

Note: All new enrollments will be picked up with the nightly batch processing. Once processed, either the new enrollment record will be created or the record will show up on the suspense report. All suspense or updates to the record will need to be made in the DPRS mainframe, by internal DPRS personnel.



View Certified SF 2809

View Certified SF 2809 displays records that have been certified and processed in the nightly batch job.

Note: This is an NFC Operations function only.

1. On the DPRS Main Menu, enter the enrollee's SSN.
2. Click **View Certified SF2809**.

The screenshot shows the DPRS Menu Page with a blue background. At the top, there are navigation tabs for HOME, DPRS, and REPORTS, and a LOGOUT link. The main heading is "DPRS Menu". Below this, there is a section titled "Enter a Social Security Number and choose a button." with a text input field for the Social Security Number. Underneath are four buttons: "Add Registration SF2809", "Search/Complete Registration SF2809", "Correct Registration SF2809", and "View Certified SF2809". Below this is another section titled "Enter a Name and choose Search Name button." with input fields for First Name, Middle Initial, and Last Name (marked with an asterisk). A "Search Name" button is located at the bottom of this section.

Figure 22: DPRS Menu Page



- The SF 2809 Part A, Enrollee Information page is displayed. Each page of the certified SF 2809 will be available for review.

HOME DPRS REPORTS [LOGOUT](#)

SF2809 Part A

[Family Info](#) [Part B](#) [Part C](#)

Enrollee Information

Public Law *	Relationship To Employee *	Current Enrollment Plan	New Enrollment Plan *	
100-654 - TCC	Former Spouse		104	
First Name *	Middle Initial	Last Name *	Social Security Number *	
Jane	C	Smith	XXXXXXXXXX	
Date of Birth *	Sex *	Married *	Country	Domestic
09-27-1951	Female	No	UNITED STATES	Yes
Address 1 *	Address 2	City *	State *	Zip *
308 Dog Rd		City	State	XXXXXX
* Enter at least one phone number				
Home Phone	Work Phone	Cell Phone	Email	
XXXXXXXXXX			Janesmith@live.com	
Other Insurance	Medicare Claim Number	Other Insurance Name	Insurance Policy Number	
None				
SON Number *				
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Figure 23: SF2809 Part A, Enrollee Information Page



Search/Complete Registration SF 2809

To search/complete original enrollee and/or dependent information.

In order to correct any registration for the original enrollee and/or dependent information, the registration cannot be certified in the mainframe. If the enrollee has been certified, follow the instructions under *Corrections* (on page 60).

1. On the DPRS Main Menu, enter the enrollee's SSN.
2. Click **Search/Complete Registration SF2809**.

HOME DPRS REPORTS [LOGOUT](#)

DPRS Menu

Enter a Social Security Number and choose a button.

Social Security Number

Enter a Name and choose Search Name button.

First Name

Middle Initial

Last Name *

Figure 24: DPRS Menu Page



3. The SF 2809 Part A, Enrollee Information page is displayed. Only a certified official can modify the registration.

SF2809 Part A

Family Info Part B Part C Save SF2809 Back

Enrollee Information

Public Law *	Relationship To Employee *	Current Enrollment Plan	New Enrollment Plan *
100-654 - TCC	Former Spouse		104
First Name *	Middle Initial	Last Name *	Social Security Number *
Jane	C	Smith	XXXXXXXXXX
Date of Birth *	Sex *	Married *	Country Domestic
09-27-1951	Female	No	UNITED STATES Yes
Address 1 *	Address 2	City *	State * Zip *
308 Dog Rd		City	State XXXXX
* Enter at least one phone number			
Home Phone	Work Phone	Cell Phone	Email
XXXXXXXXXX			Janesmith@live.com
Other Insurance	Medicare Claim Number	Other Insurance Name	Insurance Policy Number
None			
SON Number *			
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Figure 25: SF2809 Part A, Enrollee Information Page

4. Each SF 2809 page (Part A, B, C, and Family Information) of the registration can be corrected.
5. Once the fields are completed and/or corrected, click **Save SF2809** or **Save** on each individual SF 2809 page.

Note: The Search/Complete Registration SF2809 page contains the same fields as the Add Registration SF2809 page. The SF 2809 Part A, Enrollee Information; Part B; Part C; and Family Information pages of instructions can be used when completing the fields on the Search/Completed Registration SF2809 page.



Submitting Transfers and Corrections

Agencies must follow the existing DPRS process when transferring or correcting an existing account. The transfer/correction process in DPRW will be phased in at later date.

HR agencies and OPM will mail/fax all SF 2809s and SF 2810s for transfers and corrections to NFC for processing. Once received, NFC Operations reviews the forms and returns any incomplete or inaccurate forms back to the Agency. All complete forms are then entered by the NFC Operations staff into the DPRS mainframe system. After the nightly processing, either a new enrollment record or a suspense record is created in DPRS. NFC Operations reviews and clears all suspense in DPRS.

Send all completed forms and/or files to:

USDA, National Finance Center
DPRS Billing Unit
P.O. Box 61760
New Orleans, Louisiana 70161-1760

OR

Fax to:

1-303-274-3805

This section includes the following topics:

Transfers	59
Corrections	60

Transfers

NOTE: Agencies must follow the existing DPRS process when transferring an existing account. The transfer process in DPRW will be phased in at later date.

Agencies that are maintaining existing P.L. 98-615 and P.L. 100-654 (5 U.S.C. 8905a) accounts within their own systems may transfer those accounts to NFC. (Do not transfer an employee when they separate from your employment. These employees should be terminated and then submitted to NFC as a new enrollment.)

When transferring an existing account, conversion of billing from the original Agency to NFC must be coordinated. Agencies should call the DPRS Billing Unit at NFC at **1-800-242-9630** for more information.

Agencies will prepare, process, and distribute an SF 2810 documenting the transfer out of the Agencies' DPRS processing to NFC. In addition to the SF 2810, Agencies will provide NFC with



the Official Personnel File (OPF) copy of the initialed SF 2809. See an example of the ***SF 2810 and Original SF 2809 for Transfer Enrollees*** (on page 80). For instructions on filling out the SF 2810, see ***Appendix III, Instructions on Completing the SF 2810*** (on page 94). P.L. 98-615 enrollee health benefits files should be sent to NFC under a separate cover sheet. Agencies should verify the address and phone number on the SF 2809 for accuracy.

Based on receipt of these forms from the Agencies, NFC will prepare SF 2810s to transfer in the enrollees and will establish an account for each enrollee involved in the transfer. No active accounts with an overdue premium should be transferred into NFC until the overdue amount has been collected.

Send the completed forms to:

**USDA, National Finance Center
DPRS Billing Unit
P.O. Box 61760
New Orleans, Louisiana 70161-1760**

Summary of DPRS Responsibilities To Transfer Existing Accounts

- **Agencies:**
 - Prepare SF 2810 and establish each transferred enrollee into DPRS.
 - Forward copies of SF 2810, OPF, and initialed SF 2809 to NFC.
- **NFC:**
 - Generate SF 2810 copy to FEHB carrier.
 - Forward enrollee coupon book for making payments through lock box.
 - Monitor enrollee accounts.
 - Provide reporting to OPM and carrier.

Corrections

Note: Agencies must follow the existing DPRS process when correcting an existing account. The transfer process in DPRW will be phased in at later date.

In order to correct any registration for the original enrollee and/or dependent information, the registration cannot be certified in the mainframe. If the enrollee has been certified, follow the instructions below.

1. Correction processing is necessary when the erroneous information given on the SF 2809 or the SF 2810 affects a person's entitlement (e.g., errors in enrollee's name, SSN, family members, enrollment code, effective date, or similar errors). Depending on the type of error and who became aware of it, NFC either receives a completed SF 2809 or SF 2810



from the Agency for processing or NFC prepares and processes an SF 2809 or SF 2810 to correct the error. The SF 2809 or SF 2810 must be clearly labeled "correction"; must include the enrollee's name and SSN; and should show the items to be corrected. The forms are processed and copies distributed as described in the appropriate sections above. Also, NFC will send each affected carrier the appropriate copy of the corrected SF 2809.

2. If the incorrect action was processed, the personnel office should send a corrected SF 2809 or SF 2810 to NFC indicating the erroneous information in the remarks field. (See ***SF 2809 and SF 2810 for Corrections*** (on page 82).) The enrollee's copy should be sent to the enrollee. NFC will perform the necessary actions to "void" the SF 2809 or SF 2810 action that was erroneously processed. NFC will generate the respective carrier's copy (under cover of the SF 2811, Transmittal and Summary Report to Carrier).

Change/Cancel/Terminate an Enrollment

- Enrollee:
 - Prepare SF 2809 and forward to NFC.
- NFC:
 - Process or generate SF 2809/SF 2810 to accomplish change, cancelation, or termination.

For more information see:

Correct Registration in DPRW61

Correct Registration in DPRW

The following information is provided for Agencies to make corrections. If the initialed SF 2809 or SF 2810 is incorrectly prepared in DPRW and has not been certified, Agencies must go to the correct registration to make the appropriate correction and certify.

1. On the DPRS Main Menu, enter the enrollee's SSN.



2. Click **Correct Registration SF2809**.

HOME DPRS REPORTS [LOGOUT](#)

DPRS Menu

Enter a Social Security Number and choose a button.

Social Security Number

Add Registration SF2809 Search/Complete Registration SF2809 Correct Registration SF2809

View Certified SF2809

Enter a Name and choose Search Name button.

First Name

Middle Initial

Last Name *

Search Name

Figure 26: DPRS Menu Page

3. The SF 2809 Part A, Enrollee Information page is displayed. Only a certified official can modify the registration.

HOME DPRS REPORTS [LOGOUT](#)

SF2809 Part A

[Family Info](#) [Part B](#) [Part C](#)

Enrollee Information

Public Law * Relationship To Employee * Current Enrollment Plan New Enrollment Plan *

100-654 - TCC Former Spouse 104

First Name * Middle Initial Last Name * Social Security Number *

Jane C Smith XXXXXXXXX

Date of Birth * Sex * Married * Country Domestic

09-27-1951 Female No UNITED STATES Yes

Address 1 * Address 2 City * State * Zip *

308 Dog Rd City State XXXXX

* Enter at least one phone number

Home Phone Work Phone Cell Phone Email

XXXXXXXXXX Janesmith@live.com

Other Insurance Medicare Claim Number Other Insurance Name Insurance Policy Number

None

SON Number *

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Figure 27: SF2809 Part A, Enrollee Information Page

4. Each individual SF 2809 page (Part A, B, C, and Family Information) of the registration can be corrected.
5. Once the fields are corrected, click **Save SF2809** or **Save** on each individual SF 2809 page.



Note: The Correct Registration SF2809 page contains the same fields as the Add Registration SF2809 page. The SF2809 Part A, Enrollee Information; Part B; Part C; and Family Information pages of instructions can be used when completing the fields on the Search/Completed Registration SF2809 page.



DPRS Reports Generated

NFC will maintain records in such a manner as to facilitate the prompt and accurate updating of accounts and summarization for financial reporting to OPM. NFC will maintain adequate controls to ensure the accuracy of the remittances by each enrollment code.

For more information see:

Reports from DPRS Mainframe	64
Reports from Direct Premium Remittance Web (DPRW).....	65

Reports from DPRS Mainframe

NFC will assume the responsibility for providing OPM with the following reports:

- **SF 2812** - Report of Withholdings and Contributions for Retirement, Health Benefits, and Group Life Insurance.
- **SF 2812A** - Report of Withholdings and Contributions for Health Benefits by Enrollment Code.
- **OPM 1523** - Semiannual Headcount Reporting.
- **DPRS 1501** - Report on all initial SF 2809s and SF 2810s processed in the previous month.
- **DPRS 1601** - Report indicating individual retirement record changes for the spouse equity.

NFC will assume responsibility for providing FEHB carriers with the SF 2811. At the request of an FEHB carrier, NFC will provide a magnetic tape and/or list of plan enrollees. Carriers will use the list in their reconciliation of enrollees. In the case of a discrepancy, NFC will be notified by the carrier and asked to provide the necessary documentation (normally, copies of the SF 2809 or SF 2810) to resolve the problem.

For verification purposes, NFC will provide each submitting office with a report (DPRS 1501) giving information on all initial SF 2809/SF 2810 activity processed in the previous monthly cycle. (See *DPRS 1501 and 1601 Reports* (on page 85) for an example of DPRS 1501.)

NFC will provide each submitting office with a report (DPRS 1601) indicating any changes, terminations, or cancelations in enrollment for Spouse Equity Accounts. This report should be forwarded to the retirement section of the payroll office to note on the employee's retirement master record (SF 2806-1/SF 3101) any spouse equity enrollments, cancelations, terminations, or reinstatements. (See *DPRS 1501 and 1601 Reports* (on page 85) for an example of DPRS 1601.)



Reports from Direct Premium Remittance Web (DPRW)

NFC will assume the responsibility for providing OPM with the following reports:

- **DPRS Incomplete SF 2809** - Report identifies all records that have been saved in DPRW but not certified.

DPRW provides an Incomplete SF 2809 Report. This report identifies all records that have been saved in DPRW but not certified. A list of plan enrollees will be provided with the option to complete or delete the registration. (See *DPRS Incomplete SF 2809 Report* (on page 86) for an example.)

Button	Description
Complete	Opens the record for editing and completion.
Delete	Deletes the uncertified record.

For more information see:

Completing an Incomplete SF 2809 Report in DPRW..... 65

Completing an Incomplete SF 2809 Report in DPRW

When the user selects the **Reports** option on any of the DPRW pages (see an example of the *DPRS Incomplete SF 2809 Report* (on page 86)), a reports menu page will be displayed providing a category for the Incomplete SF 2809 report to be selected.

The Incomplete SF 2809 Report will provide a list of individuals that are missing information to complete the registration (SSN, First Name, Last Name, Home Phone, Email, Updated By, and Date of Last Update). The report offers the option to complete or delete the individual's SF 2809. The Agencies may run this report at any time.



To review the report in DPRW:

1. Select **Reports**. The Incomplete SF 2809 Report is displayed.



Figure 28: DPRS Incomplete SF2809 Report Page

2. Click **Incomplete SF2809 Report**. The Incomplete SF 2809 Report page is displayed.

The screenshot shows the 'Incomplete SF2809 Report' page. It features a table with columns for SSN, FirstName, LastName, HomePhone, Email, Updated By, Date of Last Update, and Action. The table contains 18 rows of data. A 'Back' button is visible above the table.

SSN	FirstName	LastName	HomePhone	Email	Updated By	Date of Last Update	Action
XXXXXXXXXX	Sally	DICKIE	XXXXXXXXXX		NF000	3/19/2013 9:23:15 AM	Complete Delete
XXXXXXXXXX	RUSSO	RETRO	XXXXXXXXXX		NF000	1/14/2013 2:11:45 PM	Complete Delete
XXXXXXXXXX	EUGENE	EMPLOY	XXXXXXXXXX		NF000	1/11/2013 8:08:56 AM	Complete Delete
XXXXXXXXXX	KIRA	KIND			NF000	1/11/2013 8:13:02 AM	Complete Delete
XXXXXXXXXX	JESSICA	TRAINING	XXXXXXXXXX		NF000	1/15/2013 2:33:36 PM	Complete Delete
XXXXXXXXXX	JEFFERY	MANDATORY	XXXXXXXXXX		NF000	1/16/2013 10:19:47 AM	Complete Delete
XXXXXXXXXX	STEVEN	SEPARATION	XXXXXXXXXX		NF000	1/3/2013 12:00:00 AM	Complete Delete
XXXXXXXXXX	lilian	lilly	XXXXXXXXXX			1/3/2013 12:00:00 AM	Complete Delete
XXXXXXXXXX	MICHAEL	MANDEVILLE	XXXXXXXXXX		NF000	1/3/2013 12:00:00 AM	Complete Delete
XXXXXXXXXX	RICHARD	RETIREMENT	XXXXXXXXXX		NF000	1/14/2013 2:56:14 PM	Complete Delete
XXXXXXXXXX	jane	doe	XXXXXXXXXX			2/21/2013 2:08:46 PM	Complete Delete
XXXXXXXXXX	Darryl	DEBT	XXXXXXXXXX			2/8/2013 12:28:57 PM	Complete Delete
XXXXXXXXXX	Transfer	Test	XXXXXXXXXX		NF000	3/11/2013 10:21:29 AM	Complete Delete
XXXXXXXXXX	Jennifer	MONEY	XXXXXXXXXX		NF000	2/5/2013 12:02:04 PM	Complete Delete
XXXXXXXXXX	Sally	John			NF000	2/21/2013 8:14:54 AM	Complete Delete
XXXXXXXXXX	Jill	Jack	XXXXXXXXXX		NF000	2/21/2013 8:15:17 AM	Complete Delete
XXXXXXXXXX	SUNG	SANG	XXXXXXXXXX		NF000	2/21/2013 8:49:16 AM	Complete Delete

Figure 29: Incomplete SF2809 Report Page

3. Click **Complete** to update and complete the registration.



OR

Click **Delete** if the enrollee needs to be removed from DPRW.

4. To exit the report, select the applicable DPRW page.

OR

Click **Back** on the Incomplete SF 2809 Report page.



Forms and Reports

The following provide examples on the different enrollment forms and reports.

This section includes the following topics:

SF 2809, Health Benefits Election Form	70
SF 2810, Notice of Change in Health Benefits Enrollment	73
SF 2809, Types of New Enrollments	75
SF 2810 and Original SF 2809 for Transfer Enrollees.....	80
SF 2809 and SF 2810 for Corrections	82
DPRS 1501 and 1601 Reports	85
DPRS Incomplete SF 2809 Report.....	86



SF 2809, Health Benefits Election Form

See *Appendix II, Instructions on Completing the SF 2809¹* for detail instructions on completing the SF 2809 form.

¹ SF 2809, Health Benefits Election Form Part A - Enrollee and Family Member's Information
Field Description/Instruction
Enrollee name Enter last, first, and middle initial.
Social Security Number Enter Social Security number (SSN).
Separated employee, child, or ex-spouse's SSN.
Date of birth Enter Date of Birth (mm/dd/yyyy).
Separated employee, child, or ex-spouse's date of birth (Month, Day, and Year).
Sex Check the appropriate block (M - Male or F - Female).
Are you married? Check the appropriate block (Y - Y ...



 Federal Employees Health Benefits Program		Health Benefits Election Form			Form Approved OMB No. 3208-0160
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 (mm/dd/yyyy)	4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	5. Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Home mailing address (including ZIP Code)			7. If you are covered by Medicare, check all that apply: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	8. Medicare Claim Number	
			9. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 10 below. <input type="checkbox"/> No		
10. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other Name of other insurance: _____ Policy Number: _____ <input type="checkbox"/> FEHB An FEHB self and family enrollment covers 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			12. Preferred telephone number		
13. Name of family member (last, first, middle initial)		14. Social Security Number	15. Date of birth (mm/dd/yyyy)	16. Sex <input type="checkbox"/> M <input type="checkbox"/> F	17. Relationship code
18. Address (if different from enrollee)			19. If this family member is covered by Medicare, check all that apply: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	20. Medicare Claim Number	
			21. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 22 below. <input type="checkbox"/> No		
22. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other Name of other insurance: _____ Policy Number: _____ <input type="checkbox"/> FEHB An FEHB self and family enrollment covers 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 <input type="checkbox"/> M <input type="checkbox"/> F	29. Relationship code
30. Address (if different from enrollee)			31. If this family member is covered by Medicare, check all that apply: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	32. Medicare Claim Number	
			33. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 34 below. <input type="checkbox"/> No		
34. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other Name of other insurance: _____ Policy Number: _____ <input type="checkbox"/> FEHB An FEHB self and family enrollment covers 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 <input type="checkbox"/> M <input type="checkbox"/> F	41. Relationship code
42. Address (if different from enrollee)			43. If this family member is covered by Medicare, check all that apply: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	44. Medicare Claim Number	
			45. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 46 below. <input type="checkbox"/> No		
46. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other Name of other insurance: _____ Policy Number: _____ <input type="checkbox"/> FEHB An FEHB self and family enrollment covers 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)

U.S. Office of Personnel Management For agency distribution of copies, see page 5 of the instructions. Standard Form 2809
Revised November 2014
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Figure 30: Standard Form 2809, Health Benefits Election Form Page 1



Enrollee name: _____ Date of birth: _____

Part B - FEHB Plan You Are Currently Enrolled In (if applicable)		Part C - FEHB Plan You Are Enrolling In or Changing To	
1. Plan name	2. Enrollment code	1. Plan name	2. Enrollment code
_____	_____	_____	_____
Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2)		Part E - Election NOT to Enroll (Employees Only)	
1. Event code	2. Date of event	<input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
_____	_____		
Part F - Cancellation of FEHB		Part G - Suspension of FEHB (Annuity/Former Spouses Only)	
<input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		<input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
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)	
_____		_____	
Part I - To be completed by agency or retirement system			
<i>REMARKS</i>			

1. Date received (mm/dd/yyyy)	2. Effective date of action (mm/dd/yyyy)	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	
_____	_____	() _____	

Standard Form 2809
Reverse of revised November 2014
Previous edition is not usable

Figure 31: Standard Form 2809, Health Benefits Election Form Page 2



SF 2810, Notice of Change in Health Benefits Enrollment

See *Appendix III, Instructions on Completing the SF 2810* (on page 94) for detail instructions on completing the SF 2810 form.

 Federal Employees Health Benefits Program		Notice of Change in Health Benefits Enrollment	
Part A - Identifying Information			
1. Name (Last, first, middle initial)		2. Date of birth	3. Social security number
4. Home address (including ZIP Code)		5. Payroll office number	6. Enrollment code number
		7. SF 2811 Report number	8. Date this action becomes effective
Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.			
Part B - Termination			
Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date. <i>Important Notice: You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.</i>			
If termination is due to death of enrollee enter date of death		Date of death (mo, dy, yr)	
Part C - Transfer In		Part D - Reinstatement	
The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.		Your enrollment has been reinstated effective on the date in Part A, item 8, above.	
Part E - Change in Name of Enrollee		Part F - Change In Enrollment-Survivor Annuitant	
The name under which this enrollment is carried has been changed to:		Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)	
Name	Date of Birth	New Enrollment Code Number <input style="width: 100px;" type="text"/>	
Address (including ZIP Code) if different from Part A, item 4, above.			
Part G - Remarks			
Part H - Date of Notice			
<i>Note: Instructions for Employing Offices are on the back of Copy 4 of this form.</i>			
Name and address of agency (including ZIP Code)		Personnel contact and telephone number	
		Payroll contact and telephone number	
Signature of authorized agency official			Date
U.S. Office of Personnel Management CSRS/FERS Handbook for Personnel and Payroll Offices		NSN 7540-01-232-1234 Copy 1 - To Enrollee	Previous edition is usable 2810-104 Standard Form 2810 Revised June 1995

Figure 32: SF 2810, FEHB Notice of Change in Health Benefits Enrollment (Part A)



Part B - Termination

If Part B on the other side of this form is checked, read the following instructions carefully.

31-Day Extension of Coverage

Your enrollment terminates on the date shown in Part A, item 8, on the front of this form. Coverage under your enrollment continues temporarily for 31 days from the date shown. If you, or any covered member of your family, are a patient in a hospital on the 31st day of this temporary extension, benefits of the plan may continue for the rest of that confinement, but not beyond 60 more days.

Conversion to Nongroup Contract

You may convert your enrollment to a nongroup contract, without evidence of good health. The nongroup contract to which you may convert is one regularly offered by your plan. It may differ from your group plan in benefits, or cost, or both, and you will have to pay the entire cost of the nongroup contract directly to the plan. The nongroup contract is effective on the day after your 31-day extension of coverage ends.

If you are interested in converting to a nongroup contract, write for information to the nearest office of the plan in which you have been enrolled (see the plan's brochure or ask your employing office for the address of the plan's nearest office). The plan will promptly send you an application form and details concerning benefits and rates of the nongroup contract to which you may convert.

Time Limit on Conversion

Normally, to be eligible for conversion, you must send your written request for information to your plan within 31 days after the date shown in Part H. However, if the date shown in Part H is more than 60 days after the date your enrollment terminates (Part A, item 8), you must forward it to your plan within 91 days after the date shown in Part A, item 8.

If you are prevented by causes beyond your control from submitting a timely request for information about conversion to a nongroup contract, you should write to your plan as soon as possible asking approval of a belated conversion opportunity. Explain fully the circumstances that

prevented earlier action and attach proof of the loss of group coverage (e.g., Standard Form 50 terminating Federal employment). A plan may consider requests filed within 6 months after group eligibility ends. If your plan needs assistance in processing your request, it should contact OPM.

Temporary Continuation of Coverage

If you are an employee whose enrollment is terminating because you are separating from service (including separation for retirement), you may be eligible to temporarily continue your benefits coverage under the Federal Employees Health Benefits Program after separation. Within 61 days after the date shown in Part A, item 8, on the front of this form, your employing office will formally notify you of your rights regarding temporary continuation of coverage and tell you where you may obtain additional information. You will have 60 days after the later of (1) your date of separation from service, or (2) the date you receive the notice from your employing office in which to elect temporary continuation of coverage.

When your temporary continuation of coverage expires, you will be entitled to the 31-day extension of coverage and the opportunity to convert to a nongroup contract.

Entry on Active Military Duty

If you elected to terminate your enrollment because you are entering military service, you may convert to a nongroup contract even though your family members are entitled to care under the Uniformed Services Health Benefits Program. If you return to civilian duty in the exercise of reemployment rights, your enrollment will be reinstated effective on the day you return to active duty. If you return to civilian duty not in the exercise of reemployment rights, you must, if eligible for coverage, register again the same as a new employee. If you are an annuitant, your enrollment will be reinstated on the day you are separated from military service. You must notify your retirement system of this event by furnishing a copy of your separation papers.

Part C - Transfer of Enrollment

If Part C on the other side of this form is checked, read carefully whichever of the following instructions applies:

Transfer of Employment

Your enrollment has been transferred from your previous agency or payroll office to the agency or payroll office shown in Part H. If you are in a prepaid comprehensive medical plan and you left the area served by the plan, you may be able to change to another plan. For details about your right to change plans, check with your employing office.

Retirement

Your enrollment has been transferred from your employing agency to the retirement system shown in Part H. Your enrollment continues automatically during retirement if you retire on an immediate annuity and you have been enrolled under the Federal Employees Health Benefits Program for the lesser of (1) all your service since your first opportunity to enroll, or (2) the 5 years of service immediately preceding retirement. Your share of the cost of your enrollment will be withheld from your annuity.

Death

The enrollment of the deceased employee named in Part A has been transferred to the retirement system shown in Part H. If the deceased employee or annuitant was enrolled for self and family at the time of death, and if at least one member of the family is entitled to a survivor annuity (or the widow(er) is entitled to the Basic Employee Death Benefits under FERS), coverage for each family member who was covered by the employee's enrollment continues automatically.

If there is only one eligible survivor, the enrollment will be changed from family coverage to self only. The survivor's share of the cost of the enrollment will be deducted from the annuity. Application for Death Benefits (Standard Form 2800 or the equivalent) should be filed promptly to avoid any question about health benefits coverage. When the survivor annuity is approved, another form like this one will be issued to show that the enrollment is being continued in the survivor's name.

Employees' Compensation

Your enrollment has been transferred to the Office of Workers' Compensation Programs. Your enrollment continues automatically while you receive monthly compensation from the Office of Workers' Compensation Programs if the Secretary of Labor has held that you are unable to return to duty and if you have been enrolled under the Federal Employees Health Benefits Program for the lesser of (1) all your service since your first opportunity to enroll, or (2) the 5 years of service immediately preceding the start of your compensation. Enrollment of covered family members of a deceased employee or compensation recipient also continues automatically while they receive monthly compensation, if (1) the deceased employee or compensation recipient was enrolled for self and family at the time of death, and (2) at least one of the covered family members is entitled to compensation as a surviving beneficiary under the Federal Employees' Compensation Act. The compensation recipient's or survivor's share of the cost of the enrollment will be deducted from the compensation checks.

Keep This Form For Your Records

Back, Copy 1
Standard Form 2810
Revised June 1995

Figure 33: SF 2810, FEHB Notice of Change in Health Benefits Enrollment (Part B)



SF 2809, Types of New Enrollments

New enrollment under the Spouse Equity law.

 Federal Employees Health Benefits Program		Health Benefits Election Form			Form Approved OMB No. 3206-0160
Part A - Enrollee and Family Member Information (For additional family members use a separate sheet and attach.)					
1. Enrollee name (last, first, middle initial) Enrollees Name		2. Social Security number XXX-XX-XXXX	3. Date of birth (mm/dd/yyyy) XX/XX/XXXX	4. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	5. Are you married? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
6. Home mailing address (including ZIP Code) Enrollees Address		7. If you are covered by Medicare, check all that apply. A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>		8. Medicare Claim Number	
City/State/ZIP		9. Are you covered by insurance other than Medicare? Yes, indicate in item 10 below. <input type="checkbox"/> No <input type="checkbox"/>			
10. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
11. Name of family member (last, first, middle initial)		12. Social Security number	13. Date of birth (mm/dd/yyyy)	14. Sex M <input type="checkbox"/> F <input type="checkbox"/>	15. Relationship code
16. Address (if different from enrollee)		17. If you are covered by Medicare, check all that apply. A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>		18. Medicare Claim Number	
City/State/ZIP		19. Are you covered by insurance other than Medicare? Yes, indicate in item 20 below. <input type="checkbox"/> No <input type="checkbox"/>			
20. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
21. Email address (if home address is different from enrollee's)			22. Preferred telephone number (if home address is different from enrollee's)		
23. Name of family member (last, first, middle initial)		24. Social Security number	25. Date of birth (mm/dd/yyyy)	26. Sex M <input type="checkbox"/> F <input type="checkbox"/>	27. Relationship code
28. Address (if different from enrollee)		29. If you are covered by Medicare, check all that apply. A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>		30. Medicare Claim Number	
City/State/ZIP		31. Are you covered by insurance other than Medicare? Yes, indicate in item 32 below. <input type="checkbox"/> No <input type="checkbox"/>			
32. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
33. Email address (if home address is different from enrollee's)			34. Preferred telephone number (if home address is different from enrollee's)		
35. Name of family member (last, first, middle initial)		36. Social Security number	37. Date of birth (mm/dd/yyyy)	38. Sex M <input type="checkbox"/> F <input type="checkbox"/>	39. Relationship code
40. Address (if different from enrollee)		41. If you are covered by Medicare, check all that apply. A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>		42. Medicare Claim Number	
City/State/ZIP		43. Are you covered by insurance other than Medicare? Yes, indicate in item 44 below. <input type="checkbox"/> No <input type="checkbox"/>			
44. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
45. Email address (if home address is different from enrollee's)			46. Preferred telephone number (if home address is different from enrollee's)		
NSN 7540-01-231-8227 U.S. Office of Personnel Management		(continued on the reverse)		Standard Form 2809 Revised August 2011 Previous edition is not usable	
For agency distribution of copies, see page 5 of the instructions.					

Figure 34: SF 2809, FEHB Health Benefits Election Form, Under the Spouse Equity Law (Part A)



Part B - FEHB Plan You Are Currently Enrolled In (if applicable)		Part C - FEHB Plan You Are Enrolling In or Changing To	
1. Plan name BCBS	2. Enrollment code 104	1. Plan name	2. Enrollment code
Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2)		Part E - Election NOT to Enroll (Employees Only)	
1. Event code 3A	2. Date of event XX / XX XXXX	<input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
Part F - Cancellation of FEHB		Part G - Suspension of FEHB (Annuitants/Former Spouses Only)	
<input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		<input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
Part H - Signature			
<i>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.)</i>			
1. Your signature (do not print) Enrollee's Signature		2. Date (mm/dd/yyyy) XX / XX / XXXX	
3. Email address Enrollee's email address		4. Preferred telephone number (XXX) XXX-XXXX	
Part I - To be completed by agency or retirement system			
SON 0119		Original Employee: First Name, Last Name	
Exspouse: P.L.98-615 (5USL 890.5a)		SSN: XXX-XX-XXXX	
		DOB: XX/XX/XXXX	
1. Date received (mm/dd/yyyy) XX/XX/XXXX	2. Effective date of action (mm/dd/yyyy) XX/XX/XXXX	3. Personnel telephone number (XXX) XXX-XXXX	
4. Name and address of agency or retirement system Agency Name		5. Authorizing official (please print) Authorized Official's Name	
Agency Address City/State/ZIP		6. Signature of authorized agency official Authorized Official's Signature	
7. Payroll office number XX XX XXXX	8. Payroll office contact (please print) Name of a Payroll's contact	9. Payroll telephone number (XXX) XXX-XXXX	

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Figure 35: SF 2809, FEHB Health Benefits Election Form, Under the Spouse Equity Law (Part B)



New enrollment under the TCC law.

 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) Enrollees Name		2. Social Security number XXX-XX-XXXX	3. Date of birth (mm/dd/yyyy) XX/XX/XXXX	4. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
6. Home mailing address (including ZIP Code) Enrollees Address		7. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	5. Are you married? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
City/State/ZIP		8. Medicare Claim Number	9. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 10 below. <input type="checkbox"/> No		
10. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____ <input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
11. Name of family member (last, first, middle initial) Family Member Name		12. Social Security number XXX-XX-XXXX	13. Date of birth (mm/dd/yyyy) XX/XX/XXXX	14. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	15. Relationship code 01
16. Address (if different from enrollee)		17. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	18. Medicare Claim Number		
		19. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 20 below. <input checked="" type="checkbox"/> No			
20. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____ <input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
21. Email address (if home address is different from enrollee's)		22. Preferred telephone number (if home address is different from enrollee's)			
23. Name of family member (last, first, middle initial) Family Member Name		24. Social Security number XXX-XX-XXXX	25. Date of birth (mm/dd/yyyy) XX/XX/XXXX	26. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	27. Relationship code 19
28. Address (if different from enrollee)		29. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	30. Medicare Claim Number		
		31. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 32 below. <input checked="" type="checkbox"/> No			
32. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____ <input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
33. Email address (if home address is different from enrollee's)		34. Preferred telephone number (if home address is different from enrollee's)			
35. Name of family member (last, first, middle initial)		36. Social Security number	37. Date of birth (mm/dd/yyyy)	38. Sex <input type="checkbox"/> M <input type="checkbox"/> F	39. Relationship code
40. Address (if different from enrollee)		41. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	42. Medicare Claim Number		
		43. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 44 below. <input type="checkbox"/> No			
44. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____ <input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
45. Email address (if home address is different from enrollee's)		46. Preferred telephone number (if home address is different from enrollee's)			
(continued on the reverse)					
NSN 7540-01-231-6227 U.S. Office of Personnel Management		For agency distribution of copies, see page 5 of the instructions.		Standard Form 2809 Revised August 2011 Previous edition is not usable	

Figure 36: SF 2809, FEHB Health Benefits Election Form, Under the TCC Law (Part A)



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 Kaiser 2. Enrollment code E35	
Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2) 1. Event code 4A 2. Date of event XX / XX XXXX		Part E - Election NOT to Enroll (Employees Only) <input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
Part F - Cancellation of FEHB <input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		Part G - Suspension of FEHB (Annuitants/Former Spouses Only) <input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
Part H - Signature <i>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.)</i>			
1. Your signature (do not print) Enrollee's Signature		2. Date (mm/dd/yyyy) XX / XX / XXXX	
3. Email address Enrollee's email address		4. Preferred telephone number (XXX) XXX-XXXX	
Part I - To be completed by agency or retirement system <small>DEM/DFC</small> Self: P.L.100 - 654 (5USL 8905a); Separation: XX/XX/XXXX End of PPD: XX/XX/XXXX			
1. Date received (mm/dd/yyyy) XX/XX/XXXX		2. Effective date of action (mm/dd/yyyy) XX/XX/XXXX	
4. Name and address of agency or retirement system Agency Name Agency Address City/State/ZIP		3. Personnel telephone number (XXX) XXX-XXXX 5. Authorizing official (please print) Authorized Official's Name 6. Signature of authorized agency official Authorized Official's Signature	
7. Payroll office number XX XX XXXX		8. Payroll office contact (please print) Payroll's Contact Person 9. Payroll telephone number (XXX) XXX-XXXX	

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Reverse of revised August 2011
Previous edition is not usable

Figure 37: SF 2809, FEHB Health Benefits Election Form, Under the TCC Law (Part B)



New enrollment under the DOD-RIF law.

 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 (mm/dd/yyyy)	4. Sex	5. Are you married?
Enrollees Name		XXX-XX-XXXX	XX/XX/XXXX	M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
6. Home mailing address (including ZIP Code)		7. If you are covered by Medicare, check all that apply.		8. Medicare Claim Number	
Enrollees Address		A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>			
City/State/ZIP		9. Are you covered by insurance other than Medicare?			
		Yes, indicate in item 10 below.			<input checked="" type="checkbox"/> No
10. Indicate the type(s) of other insurance:					
<input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
11. Name of family member (last, first, middle initial)		12. Social Security number	13. Date of birth (mm/dd/yyyy)	14. Sex	15. Relationship code
				M <input type="checkbox"/> F <input type="checkbox"/>	
16. Address (if different from enrollee)		17. If you are covered by Medicare, check all that apply.		18. Medicare Claim Number	
		A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>			
		19. Are you covered by insurance other than Medicare?			
		Yes, indicate in item 20 below.			<input type="checkbox"/> No
20. Indicate the type(s) of other insurance:					
<input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
21. Email address (if home address is different from enrollee's)			22. Preferred telephone number (if home address is different from enrollee's)		
23. Name of family member (last, first, middle initial)		24. Social Security number	25. Date of birth (mm/dd/yyyy)	26. Sex	27. Relationship code
				M <input type="checkbox"/> F <input type="checkbox"/>	
28. Address (if different from enrollee)		29. If you are covered by Medicare, check all that apply.		30. Medicare Claim Number	
		A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>			
		31. Are you covered by insurance other than Medicare?			
		Yes, indicate in item 32 below.			<input type="checkbox"/> No
32. Indicate the type(s) of other insurance:					
<input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
33. Email address (if home address is different from enrollee's)			34. Preferred telephone number (if home address is different from enrollee's)		
35. Name of family member (last, first, middle initial)		36. Social Security number	37. Date of birth (mm/dd/yyyy)	38. Sex	39. Relationship code
				M <input type="checkbox"/> F <input type="checkbox"/>	
40. Address (if different from enrollee)		41. If you are covered by Medicare, check all that apply.		42. Medicare Claim Number	
		A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>			
		43. Are you covered by insurance other than Medicare?			
		Yes, indicate in item 44 below.			<input type="checkbox"/> No
44. Indicate the type(s) of other insurance:					
<input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
45. Email address (if home address is different from enrollee's)			46. Preferred telephone number (if home address is different from enrollee's)		

Figure 38: SF 2809, FEHB Health Benefits Election Form, Under the DOD-RIF Law (Part A)



Part B - FEHB Plan You Are Currently Enrolled In (if applicable)		Part C - FEHB Plan You Are Enrolling In or Changing To	
1. Plan name	2. Enrollment code	1. Plan name BCBS	2. Enrollment code 111
Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2)		Part E - Election NOT to Enroll (Employees Only)	
1. Event code 4A	2. Date of event XX / XX XXXX	<input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
Part F - Cancellation of FEHB		Part G - Suspension of FEHB (Annuitants/Former Spouses Only)	
<input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		<input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
Part H - Signature			
<i>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.)</i>			
1. Your signature (do not print) Enrollee's Signature		2. Date (mm/dd/yyyy) XX / XX / XXXX	
3. Email address Enrollee's email address		4. Preferred telephone number (XXX) XXX-XXXX	
Part I - To be completed by agency or retirement system			
SON 0117			
Self: P.L.102 - 484 (5 USL 8905a (d) (4)); Separation Date: XX/XX/XXXX			
Last day of PP: XX/XX/XXXX Apprpration code: 45C 100 35530A			
Agency code: AFIS			
1. Date received (mm/dd/yyyy) XX/XX/XXXX	2. Effective date of action (mm/dd/yyyy) XX/XX/XXXX	3. Personnel telephone number (XXX) XXX-XXXX	
4. Name and address of agency or retirement system Agency Name		5. Authorizing official (please print) Authorized Official's Name	
Agency Address City/State/ZIP		6. Signature of authorized agency official Authorized Official's Signature	
7. Payroll office number XXXXX	8. Payroll office contact (please print) Payroll's Contact Person	9. Payroll telephone number (XXX) XXX-XXXX	

Standard Form 2809
Reverse of revised August 2011
Previous edition is not usable

Figure 39: SF 2809, FEHB Health Benefits Election Form, Under the DOD-RIF Law (Part B)

SF 2810 and Original SF 2809 for Transfer Enrollees

To transfer out of Employment, Retirement, Death, and Employees' Compensation, the following forms are required:

- SF 2810, Notice of Change in Health Benefits Enrollment
- SF 2809, Health Benefits Election Form (Original)



Transfer Out

 Notice of Change in Health Benefits Enrollment		
Part A - Identifying Information		
1. Name (Last, First, middle initial) Enrollees Name	2. Date of birth XX/XX/XXXX	3. Social security number XXX-XX-XXXX
4. Home address (including ZIP Code) Enrollees Address City/State/Zip	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number XX/XX/XXXX	8. Date this action becomes effective XXX
Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.		
Part B - Termination		
Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date. Important Notice: You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.		
<input type="checkbox"/> If termination is due to death of enrollee enter date of death	Date of death (mo, dy, yr)	
Part C - Transfer In		Part D - Reinstatement
<input type="checkbox"/> The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.		<input type="checkbox"/> Your enrollment has been reinstated effective on the date in Part A, item 8, above.
Part E - Change in Name of Enrollee		Part F - Change in Enrollment-Survivor Annuitant
<input type="checkbox"/> The name under which this enrollment is carried has been changed to: Name _____ Date of Birth _____ Address (including ZIP Code) if different from Part A, item 4, above.		<input type="checkbox"/> Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.) New Enrollment Code Number <input type="text"/>
Part G - Remarks		
Transfer Out - National Finance Center Direct Premium Remittance System		
Part H - Date of Notice		
<i>Note: Instructions for Employing Offices are on the back of Copy 4 of this form.</i>		
Name and address of agency (including ZIP Code) Agency Address City/State/ZIP		Personal contact and telephone number Authorized Official & Phone Number _____ Personal contact and telephone number Authorized Agency Official & Phone Number _____
Signature of authorized agency official Must Have Signature		Date XX/XX/XXXX
<small>U.S. Office of Personnel Management, 2025 E Street, NW, Washington, DC 20535-1204, 2010-104, Previous edition is obsolete, Standard Form 2810, Revised June 1995</small>		

Figure 40: SF 2810, FEHB Notice of Change in Health Benefits Enrollment (Transfer Out)

Note: The Agencies need to include the original SF 2809, Health Benefits Election Form. The Agencies must verify the address and phone number on the original SF 2809 for accuracy.



SF 2809 and SF 2810 for Corrections

If an incorrect action was processed, the personnel office should send a corrected SF 2809 or SF 2810 to NFC indicating the erroneous information in the Remarks block. The SF 2809 or SF 2810 must be clearly labeled "CORRECTION".

FEHB Federal Employees Health Benefits Program		Health Benefits Election Form			Form Approved: OMB No. 3206-0160
Part A - Enrollee and Family Member Information (For additional family members use a separate sheet and attach.)					
1. Enrollee name (last, first, middle initial) Enrollees Name		2. Social Security number XXX-XX-XXXX	3. Date of birth (mm/dd/yyyy) XX/XX/XXXX	4. Sex M <input type="checkbox"/> F <input checked="" type="checkbox"/>	5. Are you married? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
6. Home mailing address (including ZIP Code) Enrollees Address		7. If you are covered by Medicare, check all that apply. A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>	8. Medicare Claim Number		
City/State/ZIP		9. Are you covered by insurance other than Medicare? Yes, indicate in item 10 below. <input checked="" type="checkbox"/> No <input type="checkbox"/>			
10. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
11. Name of family member (last, first, middle initial)		12. Social Security number	13. Date of birth (mm/dd/yyyy)	14. Sex M <input type="checkbox"/> F <input type="checkbox"/>	15. Relationship code
16. Address (if different from enrollee)		17. If you are covered by Medicare, check all that apply. A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>	18. Medicare Claim Number		
		19. Are you covered by insurance other than Medicare? Yes, indicate in item 20 below. <input type="checkbox"/> No <input type="checkbox"/>			
20. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
21. Email address (if home address is different from enrollee's)		22. Preferred telephone number (if home address is different from enrollee's)			
23. Name of family member (last, first, middle initial)		24. Social Security number	25. Date of birth (mm/dd/yyyy)	26. Sex M <input type="checkbox"/> F <input type="checkbox"/>	27. Relationship code
28. Address (if different from enrollee)		29. If you are covered by Medicare, check all that apply. A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>	30. Medicare Claim Number		
		31. Are you covered by insurance other than Medicare? Yes, indicate in item 32 below. <input type="checkbox"/> No <input type="checkbox"/>			
32. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
33. Email address (if home address is different from enrollee's)		34. Preferred telephone number (if home address is different from enrollee's)			
35. Name of family member (last, first, middle initial)		36. Social Security number	37. Date of birth (mm/dd/yyyy)	38. Sex M <input type="checkbox"/> F <input type="checkbox"/>	39. Relationship code
40. Address (if different from enrollee)		41. If you are covered by Medicare, check all that apply. A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>	42. Medicare Claim Number		
		43. Are you covered by insurance other than Medicare? Yes, indicate in item 44 below. <input type="checkbox"/> No <input type="checkbox"/>			
44. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: Name of other insurance: _____ Policy number: _____					
<input type="checkbox"/> FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.					
45. Email address (if home address is different from enrollee's)		46. Preferred telephone number (if home address is different from enrollee's)			
NSN 7540-01-231-6227 U.S. Office of Personnel Management		(continued on the reverse) For agency distribution of copies, see page 5 of the instructions.		Standard Form 2809 Revised August 2011 Previous edition is not usable	

Figure 41: SF 2809, FEHB Health Benefits Election Form (Part A Correction)



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/Blue Shields 104	
Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2) 1. Event code 2. Date of event		Part E - Election NOT to Enroll (Employees Only) I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
3A XX/XX/XXXX			
Part F - Cancellation of FEHB <input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		Part G - Suspension of FEHB (Annuitants/Former Spouses Only) I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
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) Enrollees Signature		2. Date (mm/dd/yyyy) XX/XX/XXXX	
3. Email address Enrollees Email Address		4. Preferred telephone number (XXX) XXX-XXXX	
Part I - To be completed by agency or retirement system PERS/ARFC CORRECTION: DOB from: XXXX/XXXX to: XXXX/XXXX on Ex-spouse P.L. 98-615 Original Employee Name, SSN XXX-XX-XXXX, DOB XXXX/XXXX			
1. Date received (mm/dd/yyyy) XXXX/XXXX	2. Effective date of action (mm/dd/yyyy) XXXX/XXXX	3. Personnel telephone number XXX XXX-XXXX	
4. Name and address of agency or retirement system Agency Name Agency Address City/State/ZIP		5. Authorizing official (please print) Authorized Agency Official Name	
7. Payroll office number		6. Signature of authorized agency official Must Be signed	
8. Payroll office contact (please print)		9. Payroll telephone number	

Figure 42: SF 2809, FEHB Health Benefits Election Form (Part B Correction)



OR

 Federal Employees Health Benefits Program			Notice of Change in Health Benefits Enrollment		
Part A - Identifying Information					
1. Name (Last, first, middle initial) Enrollees Name		2. Date of birth XX/XX/XXXX		3. Social security number XXX-XX-XXXX	
4. Home address (including ZIP Code) Enrollee Address City/State/ZIP		5. Payroll office number		6. Enrollment code number 104	
		7. SF 2811 Report number		8. Date this action becomes effective XX/XX/XXXX	
Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.					
Part B - Termination					
Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date. Important Notice: You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage. If termination is due to death of enrollee enter date of death					
				Date of death (mo, dy, yr)	
Part C - Transfer In			Part D - Reinstatement		
The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.			Your enrollment has been reinstated effective on the date in Part A, item 8, above.		
Part E - Change in Name of Enrollee			Part F - Change In Enrollment-Survivor Annuitant		
The name under which this enrollment is carried has been changed to: Name _____ Date of Birth _____ Address (including ZIP Code) if different from Part A, item 4, above.			Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.) New Enrollment Code Number <input type="text"/>		
Part G - Remarks					
CORRECTION: DOB from: XX/XX/XXXX to: XX/XX/XXXX on Ex-spouse P.L. 98-615 Original Employee Name, SSN XXX-XX-XXXX, DOB XX/XX/XXXX					
Part H - Date of Notice					
<i>Note: Instructions for Employing Offices are on the back of Copy 4 of this form.</i>					
Name and address of agency (including ZIP Code) Agency Name Agency Address City/State/ZIP			Personnel contact and telephone number Authorized Official's Name Payroll contact and telephone number Authorized Agency Official		
Signature of authorized agency official Must be Signed by Authorized Agency Official					Date XXXXXX
U.S. Office of Personnel Management CSRS/FERS Handbook for Personnel and Payroll Offices		NSN 7540-01-232-1234		Copy 1 - To Enrollee 2810-104	
				Previous edition is usable Standard Form 2810 Revised June 1995	

Figure 43: SF 2810, FEHB Notice of Change in Health Benefits Enrollment (Correction)



DPRS 1501 and 1601 Reports

DPRS1501

The DPRS 1501, Report of SF-2809s and SF-2810s Processed for the Month of XXXX, provides a list of SF 2809s and SF 2810s processed for the month ACCT No. (Account Number), Enrollee Name, FEHB (Federal Employee Health Benefit) Plan, ACT TKN (Action Taken), Received, Processed, Effective Dates, Evnt (Event) Code, Expire Date, AD (Add Department), Law, and Relationship.

REPORT DPRS1501		USDA-NFC				PAGE: 3				
DATE PREPARED XX/XX/XXXX		DIRECT PREMIUM REMITTANCE SYSTEM				SENSITIVE PERSONNEL DATA				
TIME PREPARED 20:16		SF2809S AND SF2810S PROCESSED				USE IS RESTRICTED				
DEPT LL SON 0107		FOR THE MONTH OF OCTOBER 2013 XXXXXXXXX DOE, JANE D								
ACCT NO.	ENROLLEE NAME	FEHB PLAN	ACT TKN	RECEIVED	PROCESSED	EFFECTIVE DATE	EXP. DATE	AD	LAW	RELATIONSHIP
XXXXXXX	DOE, JANE D	314	ENR	10/01/2013	10/23/2013	10/02/2013	4A	02/02/2015	D	2 SELF
XXXXXXXX	TRAINER, SALLY Y	111	ENR	10/01/2013	10/23/2013	10/02/2013	4A	02/28/2015	D	2 SELF
XXXXXXXX	WEB, MAIN F	111	ENR	10/24/2013	10/30/2013	10/01/2013	4A	02/28/2015	D	2 SELF
XXXXXXXX	SNAGIT, ED	112	ENR	09/25/2013	10/25/2013	09/01/2013	4A	01/31/2015	D	2 SELF
XXXXXXXX	EDT, DREW	311	ENR	09/22/2013	10/24/2013	08/01/2013	4A	12/04/2014	D	2 SELF
XXXXXXXX	REHEW, TECH	F84	ENR	09/30/2013	10/25/2013	10/01/2013	4A	02/06/2015	D	2 SELF
XXXXXXXX	PAY, DAY M	E34	ENR	09/30/2013	10/25/2013	10/01/2013	4A	02/16/2015	D	2 SELF

Figure 44: USDA - NFC, Direct Premium Remittance System, SF2809s and SF2810s Processed for the Month of XXXX 20XX

DPRS1601

DPRS 1601, Individual Retirement Record Changes for Spouse Equity, provides a list of individual retirement record changes for the spouse equity (Former Spouse: Name, ACCT No.(Account Number), and Birth Date; Original Employee: Name, ACCT No.(Account Number), Birth Date; Effective Date; and Action Taken).

REPORT DPRS1601		USDA-NFC				PAGE: 3	
DATE PREPARED XX/XX/XXXX		DIRECT PREMIUM REMITTANCE SYSTEM				SENSITIVE PERSONNEL DATA	
TIME PREPARED 18:10		INDIVIDUAL RETIREMENT RECORD CHANGES FOR SPOUSE EQUITY				USE IS RESTRICTED	
DEPT:HE SON:1166		XXXXXXXXXX TO XXXXXXXXX					
NOTE: THIS REPORT SHOULD BE FORWARDED TO THE RETIREMENT SECTION OF THE PAYROLL OFFICE TO ANNOTATE ON THE ORIGINAL EMPLOYEES RETIREMENT MASTER RECORD (SF-2806/SF-3100) OR SUPPLEMENTAL RECORD (SF-2806-1/SF-3101) ANY SPOUSE EQUITY ENROLLMENTS, CANCELLATIONS, TERMINATIONS, OR REINSTATEMENTS IN ACCORDANCE WITH FPM SUPPLEMENT B90-1, CHAPTER 17.							
* - - - - - FORMER SPOUSE - - - - - *							
NAME	ACCT NO.	BIRTHDATE					
TRAINER, TRAIN T	XXXXXXXXXX	XXXX/XXXX					
* - - - - - ORIGINAL EMPLOYEE - - - - - *							
NAME	ACCT NO.	BIRTHDATE	EFFECTIVE DATE	ACTION TAKEN			
TRAINER, TRAIN T	XXXXXXXXXX	XXXX/XXXX	XXXX/XXXX	CAN			

Figure 45: USDA - NFC, Direct Premium Remittance System, Individual Retirement Record Changes for Spouse Equity XX/XX/XXXX To XX/XX/XXXX



DPRS Incomplete SF 2809 Report

DPRS Incomplete SF2809

DPRW provides an Incomplete SF 2809 Report. This report identifies all records that have been saved in DPRW but not certified. A list of plan enrollees will be provided with the option to complete or delete the registration. The DPRS Incomplete SF 2809 Report can be ran at any time.

SSN	FirstName	LastName	HomePhone	Email	Updated By	Date of Last Update	Action
XXXXXXXXXX	Sally	DICKIE	XXXXXXXXXX		NF000	3/19/2013 9:23:15 AM	Complete Delete
XXXXXXXXXX	RUSSO	RETRO	XXXXXXXXXX		NF000	1/14/2013 2:11:45 PM	Complete Delete
XXXXXXXXXX	EUGENE	EMPLOY	XXXXXXXXXX		NF000	1/11/2013 8:08:56 AM	Complete Delete
XXXXXXXXXX	KIRA	KIND			NF000	1/11/2013 8:13:02 AM	Complete Delete
XXXXXXXXXX	JESSICA	TRAINING	XXXXXXXXXX		NF000	1/15/2013 2:33:36 PM	Complete Delete
XXXXXXXXXX	JEFFERY	MANDATORY	XXXXXXXXXX		NF000	1/16/2013 10:19:47 AM	Complete Delete
XXXXXXXXXX	STEVEN	SEPARATION	XXXXXXXXXX		NF000	1/3/2013 12:00:00 AM	Complete Delete
XXXXXXXXXX	lillian	lilly	XXXXXXXXXX			1/3/2013 12:00:00 AM	Complete Delete
XXXXXXXXXX	MICHAEL	MANDEVILLE	XXXXXXXXXX		NF000	1/3/2013 12:00:00 AM	Complete Delete
XXXXXXXXXX	RICHARD	RETIREMENT	XXXXXXXXXX		NF000	1/14/2013 2:56:14 PM	Complete Delete
XXXXXXXXXX	jane	doe	XXXXXXXXXX			2/21/2013 2:08:46 PM	Complete Delete
XXXXXXXXXX	Darryl	DEBT	XXXXXXXXXX			2/8/2013 12:28:57 PM	Complete Delete
XXXXXXXXXX	Transfer	Test	XXXXXXXXXX		NF000	3/11/2013 10:21:29 AM	Complete Delete
XXXXXXXXXX	Jennifer	MONEY	XXXXXXXXXX		NF000	2/5/2013 12:02:04 PM	Complete Delete
XXXXXXXXXX	Sally	John			NF000	2/21/2013 8:14:54 AM	Complete Delete
XXXXXXXXXX	Jill	Jack	XXXXXXXXXX		NF000	2/21/2013 8:15:17 AM	Complete Delete
XXXXXXXXXX	SUNG	SANG	XXXXXXXXXX		NF000	2/21/2013 8:49:16 AM	Complete Delete

Figure 46: DPRS Incomplete SF2809 Report Page



Appendix

This section includes the following topics:

Appendix I, Public Laws Guidelines.....87
Appendix II, Instructions on Completing the SF 280988
Appendix III, Instructions on Completing the SF 281094

Appendix I, Public Laws Guidelines

Law	Eligibility	Authorized to Enter Enrollment
98-615 Civil Service Retirement Spouse Equity Act of 1984 (Law 1)	<p>Former spouses or Federal employees or annuitants who are:</p> <p>Divorced from the employee/annuitant during his/her employment or receipt of annuity covered as a family member under FEHB enrollment at least 1 day during the 18 months prior to the marriage ending.</p> <hr/> <p>Note: This requirement is met when both the former spouse and the Federal employee or annuitant have FEHB enrollments.</p> <hr/> <p>Entitled to a portion of the Federal employee's annuity or to a former spouse annuity and has not remarried before reaching age 55.</p>	Agency, OPM, NFC Operations
100-654 Federal Employees' Health Benefits Amendments Act of 1988 (TCC)	<p>Former Federal employees who separate are eligible.</p> <p>Children of the Federal employee who lose FEHB coverage.</p> <p>Former spouses of Federal employee/annuitants who lose their status as family members.</p>	Agencies, OPM, NFC Operations
101-303 Annuitants (Laws 4)	<p>Federal employee/annuitants requesting to make contributions for health benefits through direct payments rather than through annuity withholdings if the annuity is insufficient to cover the required withholdings and for other purposes.</p>	OPM, NFC Operations
102-484 National Defense Authorization Act for Fiscal Year 1993 (DOD RIF)	<p>Department of Defense civilian employees who are involuntarily separated due to a reduction in force beginning October 23, 1992.</p>	Agencies, OPM, NFC Operations



Law	Eligibility	Authorized to Enter Enrollment
111-5 American Recovery and Reinvestment Act of 2009 (Law 5)	Any Federal employee who is terminated from employment involuntarily from 08/01/2009 through 05/31/2010 is eligible for the American Recovery and Reinvestment Act (ARRA) premium assistance.	Agencies, OPM, NFC Operations

Appendix II, Instructions on Completing the SF 2809

SF 2809, Health Benefits Election Form Part A - Enrollee and Family Member's Information

Field	Description/Instruction
Enrollee name	Enter last, first, and middle initial.
Social Security Number	Enter Social Security number (SSN). Separated employee, child, or ex-spouse's SSN.
Date of birth	Enter Date of Birth (mm/dd/yyyy). Separated employee, child, or ex-spouse's date of birth (Month, Day, and Year).
Sex	Check the appropriate block (M - Male or F - Female).
Are you married?	Check the appropriate block (Y - Yes or N - No). <u>Note: If you are separated but not divorced, you are still married.</u>
Home mailing address	Enter enrollee's mailing address. Number, street or rural route, city, State, and ZIP Code of the separated employee, child, or ex-spouse's mailing address.
If you are covered by Medicare	Check all that apply (A, B, or D).
Medicare Claim Number	Enter Medicare Claim Number. <u>Note: This number is on your Medicare card.</u>
Are you covered by insurance other than Medicare?	Check the appropriate block (Yes, indicate in item 10 below or No).



Indicate the type(s) of other insurance:	Check all that apply (TRICARE, FEHB, or Other). FEHB - An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. For Other enter the Name of other insurance and Policy Number.
Email address	Enter enrollee's email address.
Preferred telephone number	Enter the enrollee's preferred telephone number.
Name of family member	List all eligible family members (last, first, and middle initial). Spouse must be listed first.
Social Security number	Enter the dependent's SSN.
Date of birth	Enter the dependent's date of birth, (mm/dd/yyyy).
Sex	Check the appropriate block, (M = Male or F = Female).
Relationship code	Enter the appropriate code as follow: Relationship code Code Family Relationship 01 Spouse 19 Child under age 26 09 Adopted Child 17 Stepchild 10 Foster Child 99 Disabled child age 26 or older who is incapable of self support because of a physical or mental disability that began before his/her 26th birthday.
Address	Enter the street or rural route, city, State, and ZIP Code of the separated employee, child, or ex-spouse's mailing address, (number and street).
If this family member is covered by Medicare	Check all that applies. <u>Note: Including prescription drug coverage under Medicare Part D.</u>
Medicare Claim Number	Enter the Medicare Claim number. <u>Note: This number is on your Medicare card.</u>



Is this family member covered by insurance other than Medicare?	Check the appropriate block, (Yes, indicate in item 34 below or No).
Indicate the type(s) of other insurance	Check all that apply (TRICARE, FEHB, or Other). FEHB - An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. Other - Enter the Name of other insurance and Policy Number.
Email address	Enter the dependent's or enrollee's email address.
Preferred telephone number	Enter the dependent's or enrollee's preferred telephone number.
Name of family member	List all eligible family members (last, first, and middle initial). Spouse must be listed first.
Social Security number	Enter the dependent's SSN.
Date of birth	Enter the dependent's date of birth, (mm/dd/yyyy).
Sex	Check the appropriate block, (M = Male or F = Female).
Relationship code	Enter the appropriate code as follow: Relationship code Code Family Relationship 01 Spouse 19 Child under age 26 09 Adopted Child 17 Stepchild 10 Foster Child 99 Disabled child age 26 or older who is incapable of self support because of a physical or mental disability that began before his/her 26th birthday.
Address	Enter the street or rural route, city, State, and ZIP Code of the separated employee, child, or ex-spouse's mailing address, (number and street).
If this family member is covered by Medicare	Check all that applies. <u>Note: Including prescription drug coverage under Medicare Part D.</u>



Medicare Claim Number	Enter the Medicare Claim number. <hr/> <u>Note: This number is on your Medicare card.</u>
Is this family member covered by insurance other than Medicare?	Check the appropriate block, (Yes, indicate in item 34 below or No).
Indicate the type(s) of other insurance	Check all that apply (TRICARE, FEHB, or Other). FEHB - An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. Other - Enter the Name of other insurance and Policy Number.
Email address	Enter the dependent's or enrollee's email address.
Preferred telephone number	Enter the dependent's or enrollee's preferred telephone number.
Name of family member	List all eligible family members (last, first, and middle initial). Spouse must be listed first.
Social Security number	Enter the dependent's SSN.
Date of birth	Enter the dependent's date of birth, (mm/dd/yyyy).
Sex	Check the appropriate block, (M = Male or F = Female).
Relationship code	Enter the appropriate code as follow: Relationship code Code Family Relationship 01 Spouse 19 Child under age 26 09 Adopted Child 17 Stepchild 10 Foster Child 99 Disabled child age 26 or older who is incapable of self support because of a physical or mental disability that began before his/her 26th birthday.
Address	Enter the street or rural route, city, State, and ZIP Code of the separated employee, child, or ex-spouse's mailing address, (number and street).



If this family member is covered by Medicare	Check all that applies. <u>Note: Including prescription drug coverage under Medicare Part D.</u>
Medicare Claim Number	Enter the Medicare Claim number. <u>Note: This number is on your Medicare card.</u>
Is this family member covered by insurance other than Medicare?	Check the appropriate block, (Yes, indicate in item 34 below or No).
Indicate the type(s) of other insurance	Check all that apply (TRICARE, FEHB, or Other). FEHB - An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. Other - Enter the Name of other insurance and Policy Number.
Email address	Enter the dependent's or enrollee's email address.
Preferred telephone number	Enter the dependent's or enrollee's preferred telephone number.

Enter the Enrollee name and Date of birth at the top of the page.

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

Item Number	Description
Plan name	Enter the plan name.
Enrollment code	Enter the enrollment code.

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

Item Number	Description
Plan name	Enter the elected health benefits plan name.
Enrollment code	Enter the elected health benefits plan three digit enrollment code.

Part D - Event That Permits You to Enroll, Change, or Cancel

Item Number	Description
Event code	Enter the event code.
Date of event	Enter the date of event.



Part E - Election NOT to Enroll (Employees Only)

I do NOT want to enroll in the FEHB Program
Place an "X" in the box if the enrollee wishes not to enroll in the FEHB Program.

Note: Signature in Part H certifies that they have read and understand the information on page 3 regarding this election.

Part F - Cancellation of FEHB

I CANCEL my enrollment
Place an "X" in the box if the enrollee wishes to cancel FEHB enrollment.

Note: Signature in Part H certifies that they 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.
Place an "X" in the box if your are an annuitant or former spouse wishing to suspend your FEHB enrollment.

Note: Signature in Part H certifies that they 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.)

Item Number	Description
Your signature	Sign the SF 2809 form, (do not print).
Date	Enter the date the form was signed, (mm/dd/yyyy).

Part I - To Be Completed by Agency or Retirement System

REMARKS: Enter the appropriate remarks. Also, please enter the name and telephone number of the person completing this form in the Remarks block. Example: Form Completed by: Jane Doe, Telephone No. (123) 456-7890.



Item Number	Description
Date received	Enter the date received, (mm/dd/yyyy).
Effective date of action	Enter the effective date of action, (mm/dd/yyyy).
Personnel telephone number	Enter the Personnel telephone number.
name and address of agency or retirement system	Enter the name and address of Agency or retirement system.
Authorizing official	Enter the name of the Authorizing official (please print)
Signature of authorized agency official	Enter Signature of authorized Agency official.
Payroll office number	Enter the Payroll office number.
Payroll office contact	Enter the Payroll office contact (please print)
Payroll telephone number	Enter the Payroll telephone number.

Appendix III, Instructions on Completing the SF 2810

SF 2810, Notice of Change in Health Benefits Enrollment Part A - Identifying Information

Item Number	Description
Name	Enter the enrollee's name, (Last, first, and middle initial).
Date of birth	Enter the date of birth, (mm/dd/yyyy).
Social security number	Enter the enrollee's SSN.
Home address	Enter the enrollee's home address, (including ZIP Code).
Payroll office number	Enter the Payroll office number.
Enrollment code number	Enter the enrollment code number.
SF 2811 Report number	Enter the SF 2811 Report number.
Date this action becomes effective	Enter the date this action became effective.

Note: Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form unless enrollment is terminated and applying for conversion.



Part B - Termination

Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date. If termination is due to death of enrollee, enter date of death. Place an "X" in the box if the enrollee wishes to terminate.

Part C - Transfer In

Place an "X" in the box if the new payroll office has accepted transfer of this enrollment.

Part D - Reinstatement

Place an "X" in the box if enrollment has been reinstated.

Part E - Change in Name of Enrollee

Field Name	Description
Name	Enter the name under which this enrollment is carried has been changed to, (Last, first, and middle initial).
Date of birth	Enter the dat of birth, (mm/dd/yyyy).
Address	If different from Part A, item 4, above (including ZIP Code). Place an "X" in the box if name under which this enrollment is carried has been changed.

Part F - Change in Enrollment-Survivor Annuitant

Place an "X" in the box if enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. New enrollment code number will be issued.

Part G - Remarks

Enter the appropriate remarks. Also, please enter the name and telephone number of the person completing this form in the Remarks block.

Example: Form Completed by: Jane Doe, Telephone No. **(123) 456-7890**.

Part H - Date of Notice

Name and address of agency	Enter the name and address of the Agency, including ZIP Code.
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Personnel contact and telephone number	Enter the Personnel contact person and telephone number.
Payroll contact and telephone number	Enter the Payroll contact person and telephone number.
Signature of authorized agency official	Enter the signature of the authorized Agency official.
Date	Enter the date the authorized Agency official signed the form. <u>Note: If the document is not signed, it will be returned.</u>



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