PostalEASE FEHB Worksheet

Changes due to a qualifying life event (QLE) cannot be made via PostalEASE

This worksheet will help you prepare to call *PostalEASE*, or use *PostalEASE* on the Internet (https://liteblue.usps.gov), on an Employee Self-Service Kiosk (now available in some facilities) or on the Postal Service Intranet (from the Blue page). You may contact the Human Resources Shared Service Center (HRSSC) by calling 1-877-477-3273, Option 5 or TTY, 1-866-260-7507 for assistance if:

- you are deaf or hard of hearing or
- you cannot use the telephone, Internet, Employee Self Service kiosk or Intranet for a medical reason or
- you receive a message in *PostalEASE* directing you to contact the HRSSC when attempting to make a change.

Please Note:

- You will need to **provide documentation** if your election is due to a QLE and that you are contacting the HRSSC within the required time frame.

For more information on QLEs, please refer to https://liteblue.usps.gov/qle4

Except for open season and adding eligible family members, most enrollments and changes of enrollment are effective on the first day of the pay period after receipt of this form at the HRSSC. The HRSSC can give you the specific date on which your enrollment or enrollment change will take effect.

Part 1 — Employee Information

☐ Career ☐ Non-career

Your Name *(Last, First, Middle Initial)*	Employee ID

Your Gender: ☐ Male ☐ Female	**Married:** ☐ Yes ☐ No	**Daytime Telephone Number** (including area code) **Email address:**

Your Other Group Insurance *(Not used for waiving enrollment as a new employee).*

1) Are you covered by insurance other than Medicare?

☐ Yes ☐ No

If YES, indicate type of other insurance in Item 2.

2) Identify Type of Other Insurance Coverage

☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D

☐ TRICARE ☐ OTHER_____

Other Insurance Policy No. _____

(No person may be covered under more than one FEHB enrollment.)

Part 2 — Type of Action You Are Requesting

1) Open Season: ☐ New Enrollment ☐ Change Current Enrollment ☐ Cancel Enrollment

2) New Hire: ☐ New Enrollment ☐ Waive Enrollment

3) QLE or Special Enrollment

☐ New Enrollment ☐ Cancel Enrollment

☐ Change Current Enrollment ☐ Update Dependent List Only
If updating dependent list complete parts 4–7

☐ Waive Enrollment

Type of QLE Actions

In most cases enrollment must be received at the HRSSC within 60 days after the QLE

Marriage: _____ (Date)
Divorce: _____ (Date)
Birth of Child: _____ (Date)
Dependent Death: _____ (Date)
Other: _____ (Date)

Part 3 — Enrollment Plan Name And Plan Code

1) New Plan Name:

2) New Enrollment Code: _____

☐ Self Only ☐ Self Plus One ☐ Self and Family

3) Old Plan Enrollment Code *(If you are changing plans or cancelling your current plan)*

Employee Name: ______________________________ EIN: ______________

Part 4 — Dependent Information *(for Self Plus One and Self and Family coverage only)*

A complete mailing address (if different from the USPS employee's) and other insurance information, if any, must be provided for each covered dependent.

1) ☐ **Please check here if all dependents reside with you. No person may be covered by more than one FEHB enrollment.**

2) **Complete the following information for each dependent**

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship Code*

Address *(if different from enrollee)*	If covered by Medicare, check all that apply ☐ A ☐ B ☐ D	Medicare Claim Number
	Is this family member covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No	

Indicate the type(s) of other insurance:

☐ FEHB ☐ TRICARE ☐ Other Name of other insurance: ______________ Policy Number: ______

Email address *(if home address is different from enrollee's)*	Preferred telephone number *(if home address is different from enrollee's)*

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship Code*

Address *(if different from enrollee)*	If covered by Medicare, check all that apply ☐ A ☐ B ☐ D	Medicare Claim Number
	Is this family member covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No	

Indicate the type(s) of other insurance:

☐ FEHB ☐ TRICARE ☐ Other Name of other insurance: ______________ Policy Number: ______

Email address *(if home address is different from enrollee's)*	Preferred telephone number *(if home address is different from enrollee's)*

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship Code*

Address *(if different from enrollee)*	If covered by Medicare, check all that apply ☐ A ☐ B ☐ D	Medicare Claim Number
	Is this family member covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No	

Indicate the type(s) of other insurance:

☐ FEHB ☐ TRICARE ☐ Other Name of other insurance: ______________ Policy Number: ______

Email address *(if home address is different from enrollee's)*	Preferred telephone number *(if home address is different from enrollee's)*

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship Code*

Address *(if different from enrollee)*	If covered by Medicare, check all that apply ☐ A ☐ B ☐ D	Medicare Claim Number
	Is this family member covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No	

Indicate the type(s) of other insurance:

☐ FEHB ☐ TRICARE ☐ Other Name of other insurance: ______________ Policy Number: ______

Email address *(if home address is different from enrollee's)*	Preferred telephone number *(if home address is different from enrollee's)*

*Relationship Codes: 01 – Legal Spouse, 02 – Common Law Spouse (certification required), 09 – Adopted Child (adoption decree needed) Under Age 26, 10 – Foster Child Under Age 26 (certification required), 17 – Stepchild, 19 – Biological Child, 99 – Child age 26 or Older Incapable of Self-Support (medical documents required)

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Part 5 —

Employee Signature _____ **Date** _____

Email Address _____ **Preferred telephone number** _____

Acknowledgment for Non-career Employees

I acknowledge that I have researched the health plan information for my service area and I am aware of the bi-weekly premium for the plan that I've chosen. I understand that if I am not eligible for a USPS contribution, I will be responsible for 100% of the premium cost.

I understand that I must pay any invoice issued by the Eagan ASC for health benefits premium costs within 30 days of the date the invoice was issued. I further understand that if I fail to pay the invoice within the specified time, my health benefits enrollment under FEHB will be terminated retroactive to the date the initial unpaid premium was due. As a result, I will be liable to the insurance carrier and/or health care provider for any medical expenses I have incurred since the date of termination.

For HRSSC Use Only

REMARKS: *Specific information on type of qualifying life event, reason for correction, type of certification, supporting documentation, reason for verification, etc., should be provided here.*

Processing NOTES:

Employing Office:	**HRSSC COMP & BENEFITS**	LATE/UNPROCESSED ACTION? ☐ Yes ☐ No	
Address:	**PO BOX 970400**	DATE RECEIVED at HRSSC:	
City/State/ZIP Code:	**GREENSBORO NC 27497-0400**	QLE DATE:	
PROCESSED BY:	PPS ● HRSSC	EFFECTIVE DATE:	
Date Scanned To Eagan:		File copy in OPF for any FEHB transaction processed by HRSSC and ASC	

Privacy Act Statement: Your information will be used to process your enrollment in the Federal Employees Health Benefits system and to manage your claim under that plan. Collection is authorized by 39 U.S.C. 401, 409, 410, 1001, 1003, 1004,1005, and 1206 and 1206; and 29 U.S, 2601 et seq.

Providing the information is voluntary, but if not provided, we may not process your request. We may disclose your information as follows: in relevant legal proceedings; to law enforcement when the U.S. Postal Service (USPS) or requesting agency becomes aware of a violation of law; to a Congressional office at your request; to entities or individuals under contract with USPS; to entities authorized to perform audits: to labor organizations as required by law; to federal, state, local or foreign government agencies regarding personnel matters; to the Equal Employment Opportunity Commission; to the Merit Systems Protection Board or Office of Special Counsel; the Selective Service System, records pertaining to supervisors and postmasters may be disclosed to supervisory and other managerial organizations recognized by USPS; and to financial entities regarding financial transaction issues.

OPM Privacy Act and Paperwork Reduction Act Notice: The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program under Chapter 89, title 5, U.S. Code. The principle use of this information will be to share it with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. Other routine uses include disclosures to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. May also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or Social Security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency. While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment. We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB Program, and for other purposes. Executive Order 13478 (November 18, 2009) allows Federal agencies to use the Social Security Number as individual identifiers to distinguish between people with the same or similar names. Failure to furnish your Social Security Number and/or Medicare Claim Number may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies, proper coordination with Medicare and proper health insurance status reporting to the IRS.

Public Burden Statement: We think this form takes an average of 30 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, OPM Forms Officer, (3206-0160), Washington, D.C. 20415-3430. The OMS number 3206-0160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

UNITED STATES POSTAL SERVICE®

See Instructions and Privacy Act Statement on Reverse

Pre-Tax Health Insurance Premium Election/Waiver Form for Noncareer Employees

Purpose of Form 8202

PS Form 8202 is used by noncareer employees who are eligible under United States Postal Service® policy and/or collective bargaining agreements when they become eligible for Federal Employees Health Benefits (FEHB) coverage during the FEHB Open Season, or following certain qualifying life events to begin pre-tax treatment of employee FEHB premium payments or to waive pre-tax treatment if it was previously elected.

- See the reverse side of this form for definitions of pre-tax and after-tax treatment and for an important note about Internal Revenue Service (IRS) restrictions on *reduction* of coverage when pre-tax treatment is in effect.
- See the applicable *Guide to Employees Health Benefits Plan (FEHB Guide)*, provided to you by your personnel office, for information about qualifying life events.

To begin pre-tax treatment, complete Parts A, B, and D below.

To waive pre-tax treatment (only if you waived it previously) complete Parts A, C, and D below.

Part A - Participant Information *(Must be completed by all applicants. See the top line of your biweekly earnings statement for items 1-4.)*

1. Name *(Last, first, middle initial)*		2. Employee ID
3. Finance No.	4. Pay Location	5. Employing Office *(City, State, and ZIP + 4®)*
6. Participant Daytime Telephone No.	7. Participant Mailing Address *(Street, City, State, and ZIP + 4)*	

Part B - Begin Pre-Tax Treatment

_____ *(Initials)*

I elect to begin pre-tax treatment of my FEHB health insurance premium contributions and to adhere to the more restrictive IRS guidelines summarized on the reverse side of this form. My election will become effective on the first full pay period in the following calendar year (FEHB Open Season) unless I am making this election as a newly eligible noncareer employee or have a qualifying life event, in which case it will become effective the pay period after I submit this form. Pre-tax treatment will continue into future plan years unless I later complete a new PS Form 8202 during FEHB open season or following a qualifying life event to waive pre-tax treatment.

I understand that because paying my FEHB premiums with pre-tax money reduces the earnings reported to the Social Security Administration, if I begin to collect Social Security when I retire (which normally occurs at age 62 at the earliest), I may receive a lower Social Security benefit. My Medicare, life insurance, retirement plan, and Thrift Savings Plan benefits will not be affected.

Part C - Waive Pre-Tax Treatment *(Complete only if pre-tax treatment was previously elected.)*

_____ *(Initials)*

I elect to waive pre-tax treatment of my FEHB health insurance premium contributions. My election will become effective on the first full pay period in the following calendar year (FEHB Open Season) or, if I have a qualifying life event, on the pay period after I submit this form. This waiver will continue into future plan years unless I later complete a new PS Form 8202 during FEHB Open Season or following a qualifying life event to begin pre-tax treatment.

Part D - Authorization *(After reading the Privacy Act Statement on the reverse side of this form, sign and date below.)*

By signing this form I acknowledge that I have read and understand all the materials explaining the pre-tax treatment of employee contributions towards FEHB health insurance premiums.

I authorize payroll deductions for health insurance premiums in the manner indicated in Part B or Part C above.

Warning: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of law and could lead to termination of employment.	1. Your Signature *(Do not print)*	2. Date

Part E - Processing *(To be completed by Human Resources personnel.)*

1. Effective Date	2. Authorized Official Signature	3. DDE/DR Office Telephone No. *(Include area code)*

REMARKS *(For use by Human Resources personnel only.)*

UNITED STATES POSTAL SERVICE™

Notice to Noncareer Employees Eligible to Enroll in FEHBP

Subject: Sufficient Earnings Requirement for Federal Employees Health Benefits Coverage

Employee Name *(Last, first, middle initial)*	Social Security Number

Federal Employees Health Benefits Program (FEHBP) regulations provide that temporary (noncareer) employees eligible to enroll in FEHBP coverage must have withheld from their biweekly pay the *Full* cost for the health benefits premium. The Postal Service does not contribute toward health benefits for noncareer employees.

To be eligible for FEHBP coverage as a noncareer employee, your biweekly earnings must be sufficient to cover the health benefits premium withholdings, and must be expected to remain sufficient for at least 6 months.

Once enrolled in a health benefits plan, if you fail to earn sufficient pay to allow for health benefits premium withholdings in one pay period, the Minneapolis Postal Data Center (MNPDC) will withhold the unpaid premium in the following pay period, provided you have sufficient earnings to cover the unpaid premium. When two adjustments for insufficient earnings for FEHBP purposes have occurred, the MNPDC will send you an invoice for the total amount due. You must pay the total amount billed within 30 days of the date of the invoice. *If payment is not received by the MNPDC within this timeframe, your health benefits enrollment will be terminated retroactive to the date the initial unpaid premium was due.* Once you lose FEHBP coverage because of insufficient earnings, you will not be eligible to renew your enrollment until the next FEHBP open season or the occurrence of some other change in your status (e.g., conversion to career) which provides you an opportunity to enroll for health benefits coverage.

Please sign and date in the space provided below to acknowledge receipt of this information and return the completed form to your personnel office.

Employee Acknowledgement

I understand that invoices issued by the MNPDC for health benefits premium costs must be paid within 30 days of the date the invoice was issued. I further understand that failure to pay the invoice within the timeframe specified will result in the termination of my health benefits enrollment under the FEHBP noncareer provisions retroactive to the date the initial unpaid premium was due, and that this will result in my being liable to the insurance carrier for any medical expenses incurred since that date.

Employee Signature	Date *(Month, day, year)*