FEHB
Federal Employees
Health Benefits Program

Form Approved:
OMB No. 3206-0160

Health Benefits Election Form

Part A - Enrollee and Family Member Information *(for additional family members use a separate sheet and attach)*

1. Enrollee name *(last, first, middle initial)*	2. Social Security Number	3. Date of birth *(mm/dd/yyyy)*	4. Sex	5. Are you married?
Huang, Jianping	684-09-0961	05/01/1968	[x] M [ ] F	[x] Yes [ ] No

6. Home mailing address *(including ZIP Code)*
9322 Winbourne Road
Burke, VA, United States 22015

7. If you are covered by Medicare, check all that apply. [ ] A [ ] B [ ] D

8. Medicare Beneficiary Identifier

9. Are you covered by insurance other than Medicare? [x] Yes, indicate in item 10 below. [ ] No

10. Indicate the type(s) of other insurance:
[ ] TRICARE [x] Other *Name of other insurance:* Cigna Health and Life Insurance Company *Policy Number:* 00627473
[ ] FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

11. Email address
jianping.huang@noaa.gov

12. Preferred telephone number
571-528-5324

13. Name of family member *(last, first, middle initial)*	14. Social Security Number	15. Date of birth *(mm/dd/yyyy)*	16. Sex	17. Relationship code
Fang, Sujuan	212890481	07/23/1968	[ ] M [x] F	01

18. Address *(if different from enrollee)*

19. If this family member is covered by Medicare, check all that apply. [ ] A [ ] B [ ] D

20. Medicare Beneficiary Identifier

21. Is this family member covered by insurance other than Medicare? [x] Yes, indicate in item 22 below. [ ] No

22. Indicate the type(s) of other insurance:
[ ] TRICARE [x] Other *Name of other insurance:* Blue Cross and Blue Shield of Texas *Policy Number:* 121868
[ ] FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

23. Email address *(if applicable, enter email address of your spouse or adult child)*
hjpfwj@gmail.com

24. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*
5712713536

25. Name of family member *(last, first, middle initial)*	26. Social Security Number	27. Date of birth *(mm/dd/yyyy)*	28. Sex	29. Relationship code
Huang, Zhe	212890477	08/31/2000	[x] M [ ] F	19

30. Address *(if different from enrollee)*

31. If this family member is covered by Medicare, check all that apply. [ ] A [ ] B [ ] D

32. Medicare Beneficiary Identifier

33. Is this family member covered by insurance other than Medicare? [x] Yes, indicate in item 22 below. [ ] No

34. Indicate the type(s) of other insurance:
[ ] TRICARE [x] Other *Name of other insurance:* Blue Cross and Blue Shield of Texas *Policy Number:* 121868
[ ] FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

35. Email address *(if applicable, enter email address of your spouse or adult child)*
fillipuhuang@gmail.com

36. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*
5712062698

37. Name of family member *(last, first, middle initial)*	38. Social Security Number	39. Date of birth *(mm/dd/yyyy)*	40. Sex	41. Relationship code
Huang, Bill	043134462	07/15/2008	[x] M [ ] F	19

42. Address *(if different from enrollee)*

43. If this family member is covered by Medicare, check all that apply. [ ] A [ ] B [ ] D

44. Medicare Beneficiary Identifier

45. Is this family member covered by insurance other than Medicare? [x] Yes, indicate in item 22 below. [ ] No

46. Indicate the type(s) of other insurance:
[ ] TRICARE [x] Other *Name of other insurance:* Blue Cross and Blue Shield of Texas *Policy Number:* 121868
[ ] FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

47. Email address *(if applicable, enter email address of your spouse or adult child)*
hjpfwj@gmail.com

48. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*
5715285324

(Continued on the reverse)

Enrollee name: Huang, Jianping Date of birth: 05/01/1968

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 CareFirst BlueChoice-Blue Value Plus (B6	2. Enrollment code B65

Part D - Event That Permits You To Enroll, Change, or Cancel *(see page 6)*		Part E - Election NOT to Enroll *(Employees Only)*
1. Event code 1A	2. Date of event 04/08/2024	☐ I do NOT want to enroll in the FEHB Program. ***My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.***

Part F - Cancellation of FEHB	Part G - Suspension of FEHB *(Annuitants/Former Spouses Only)*
☐ I CANCEL my enrollment. ***My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.***	☐ I SUSPEND my enrollment. ***My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.***

Part H - Signature

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

1. Your signature *(do not print)*	2. Date *(mm/dd/yyyy)*
Electronically Signed by Jianping Huang	4/10/2024

Part I -To be completed by agency or retirement system

REMARKS

New hire enrollment into FEHB program.

1. Date received *(mm/dd/yyyy)*	2. Effective date of action *(mm/dd/yyyy)*	3. Personnel telephone number
4/10/2024	04/21/2024	888-316-2285

4. Name and address of agency or retirement system	5. Authorizing official *(please print)*
Department of Commerce (DOC)	Karmen Sherrod
1315 East West Hwy Silver Spring, MD United States 20910	6. Signature of authorized agency official KARMEN SHERROD (Affiliate) Digitally signed by KARMEN SHERROD (Affiliate) Date: 2024.05.09 15:30:15 -04'00'

7. Payroll office number	8. Payroll office contact *(please print)*	9. Payroll telephone number
12400001	NFC	504-255-5370