FEDERAL EMPLOYEE'S HEALTH BENEFITS
WAIVER OF IMMEDIATE REINSTATEMENT OF FEHB

Current Military Technicians who are returning from military service and have an active FEHB plan may waive FEHB reinstatement or enrollment due to military TRICARE and/or TRICARE Reserve Select coverage until such coverage has ended.

Employees may select any date between the date they restored to their technician position and within 60 days after their transitional TRICARE and/or TRICARE Reserve Select coverage ends.

Annuitants may select any date between the date they are separated from the Uniformed Service and the date after their transitional TRICARE and/or TRICARE Reserve Select coverage ends.

For further information, contact your local Human Resources Representative or visit www.opm.gov.

You are required to initial all applicable blocks to indicate your elections and that you have read and understand your options/conditions.

I. INDIVIDUAL INFORMATION

Name:_____ SSN:_____ Technician Unit:_____

Date release/discharged from military service:_____ Date TRICARE Coverage ends:_____

II. EMPLOYEES

I understand that, pursuant to the Uniformed Services Employed and Reemployment Rights ACT (USERRA), I have a right to reinstatement of my Federal Employees Health Benefits (FEHB) coverage on the day I am restored to my civilian position under the provisions of 5 CFR part 353 or similar authority.

____Initials. I hereby clearly and unequivocally waive my FEHB coverage until:_____ Date:_____

III. ANNUITANTS

I understand that the pursuant to the USERRA, I have a right to reinstatement of my FEHB coverage on the day I am separated from the uniformed services.

I fully understand that until my FEHB enrollment is reinstated, I will not be eligible for any health benefits that would have been available to me under an FEHB plan. This waiver will terminate upon my death.

____Initials. I hereby clearly and unequivocally waive my FEHB coverage until:_____ Date:_____

IV. TECHNCIAN'S SIGNATURE

I have read and understand my FEHB waiver options and the associated conditions.

Signature:_____ Date:_____

For HRO Purpose Only

1) SF 2810 Completed on _____ Date (mm/dd/yyyy)
2) SF 2810 Sent to Provider_____ Date (mm/dd/yyyy)
3) DCPDS updated_____Date (mm/dd/yyyy)

NOTE: Date track to effective date.