Conditional Offer of
Federal Employee Health Benefits Form

Check one: ☐ **BIA** ☐ **BLM** ☐ **FWS** ☐ **NPS**

NAME: _____ **SSN/ECI:** _____

PHONE: _____ **E-MAIL:** _____

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As an Administratively Determined Emergency Worker (AD/Casual), you will be eligible for Federal Employee Health Benefits (FEHB) when you work 130 hours per month for 90 consecutive days. This coverage includes a 31 day extension of FEHB following employment termination.

More information about the FEHB program is available on the OPM website: https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/.

As an AD/Casual, I understand that if I work 130 hours per month for 90 days, I am eligible for FEHB coverage.

☐ I **elect** FEHB upon meeting the above eligibility criteria.

☐ I **decline** coverage in a Federal Employee Health Benefits plan.

***I understand if at any time I choose to receive more information, I can contact the Casual Payment Center.**

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By signing below, I attest I am the person named above and I have read and understand the information presented.

SIGNATURE: _____ **DATE:** _____

Privacy Act Statement: Information on this form is collected under the authority of the Administratively Determined (AD) Pay Plan. Information collected via this form is covered by the Privacy Act of 1974 and Privacy Act System of Records Notice DOI-85. The primary use of this information is to start, stop, or change entitlements and to process any voluntary or involuntary deductions on pay and leave issues. The information you furnish will be used to identify records properly associated with you, to obtain additional information to update your record, if necessary, and to determine any present or future entitlement. Disclosure may be made only to authorized persons according to Title 5 USC 552a and for uses described in System of Records Notices DOI-85. Submission of the information in this form is voluntary; however, requests will not be completed without the information needed to process the request.

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