FEHB LWOP ELECTION FORM

Revised 11/13/05

PLEASE PRINT INFORMATION REQUESTED BELOW.

Name: _____ Home Port: East ☐ West ☐

SSN: _____ DOB: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION WHILE IN A LEAVE STATUS:

ADDRESS: _____

_____

_____

PHONE: _____

This is in reference to OPM -71, Leave Request Form, dated _____

I have read and understand the FEHB LWOP notice. I elect to:

Continue the enrollment (Check one):

- ☐ Submit direct payments
- ☐ Incur a debt and deduct from my pay upon return to pay status
- ☐ Pre-pay premiums for entire length of LWOP

I understand that my coverage will terminate after 365 days in a non-pay status regardless of my election above. I further understand that the 365 days of continued enrollment during leave without pay status is not considered to be broken by any period(s) in pay status of less than 4 consecutive months.

_____

Signature Date

☐ Terminate the enrollment

_____

Signature Date

FAX FORM TO: (757) 443-2269 OR

MAIL FORM TO: DON, MSC Military Sealift Fleet Support Command N82, 471 East C Street , Bldg SP-64 , Norfolk, VA 23511-2419