Standard Form No. 2809
CHAPTER I-5 F.P.M.
6 GAO 5000

HEALTH BENEFITS REGISTRATION FORM

FEDERAL EMPLOYEES HEALTH BENEFITS ACT OF 1959

(Read instructions on back of last page. Use only typewriter or ink pen.)

CARRIER'S CONTROL NO. 078546

APPROVED FOR RELEASE DATE: 12-Nov-2008

PART A

ALL WHO REGISTER MUST FILL IN THIS PART.

1. NAME (LAST) CARANCI (FIRST) JOHN (MIDDLE INITIAL) C.

2. DATE OF BIRTH (Use numbers): MONTH 2 DAY 7 YEAR 1922

3. Are you now married? YES [X] (b)(6) NO [ ] (b)(3)

4. YOUR MAILING ADDRESS (NUMBER AND STREET) (CITY AND ZONE NUMBER) (STATE)

[redacted]

5. SEX: MALE [X] 1 FEMALE [ ] 2

6. Are you covered by, or is any family member listed below covered by or enrolling in, a plan under the Federal Employees Health Benefits Act of 1959 (through the enrollment of another United States or District of Columbia Government employee or annuitant)? YES [ ] NO [X]

7. Place an "X" in proper box to show your annual basic salary range.

UNDER $4,000 [ ] 1 | $6,000 TO $9,999 [X] 3
$4,000 TO $5,999 [ ] 2 | $10,000 OR OVER [ ] 4

PART B

FILL IN THIS PART IF YOU WISH TO ENROLL IN A HEALTH BENEFITS PLAN.

If enrollment if for self only, answer item 1. If enrollment is for self and family, also answer item 2 and item 3 if it applies.

THIS PART MUST ALSO BE FILLED IN IF YOU CHANGE YOUR ENROLLMENT.

1. I elect to enroll in a health benefits plan as shown below. I authorize deductions to be made from my salary, compensation, or annuity to cover my share of the cost of the enrollment. (Copy the information requested below from inside cover of brochure of the plan you select.)

NAME OF PLAN	OPTION (HIGH OR LOW)	ENROLLMENT CODE NUMBER
ASSOCIATION'S PLAN	~~HIGH~~ LOW	4 2 5

2. In space below list all eligible family members without exception: List your wife or husband first, then your unmarried children under age 19, including legally adopted children, and stepchildren and illegitimate children who live with you in a regular parent-child relationship. Include also any unmarried child over 19 who became disabled before age 19 and who, because of the disability, is incapable of self-support. (Attach a doctor's certificate for a disabled child age 19 or over.)

NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)	NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)
Wife or Husband	1		6
	2		7
	3		8
	4		9
	5		10

3. If you are a female (employee or annuitant)—does the family listed above include a husband who is incapable of self-support by reason of mental or physical disability which can be expected to continue for more than one year? (If answer is "Yes," attach a doctor's certificate.) YES [ ] NO [ ]

PART C

FILL IN THIS PART IF YOU WISH **NOT** TO ENROLL OR IF YOU WISH TO CANCEL YOUR ENROLLMENT.

PLACE AN "X" IN ITEM 1 OR ITEM 2, WHICHEVER APPLIES AND ANSWER ITEM 3.

1. I elect not to enroll in any plan under the Health Benefits Act. [ ]

2. I elect to cancel my present enrollment under the Health Benefits Act. [ ]

3. The reason for my election is (Place an "X" in proper box):
   (a) I am covered by a plan under the Health Benefits Act through the enrollment of my husband, wife, or parent. [ ] 1
   (b) I am covered by a health insurance plan which is not under the Health Benefits Act. [ ] 2
   (c) Any other reason. [ ] 3

PART D

FILL IN THIS PART IF YOU WISH TO CHANGE YOUR ENROLLMENT.

I elect to change my enrollment as shown by the enrollment number and other information in Part B.

1. Enrollment code number of present plan.
2. Number of event which permits change. (See table on back of duplicate for proper number.)
3. Date of event which permits change. MONTH 58 DAY 8,25 YEAR 99

PART E

ALL WHO REGISTER MUST FILL IN THIS PART.

John C. Caranci June 13, 1960
(YOUR SIGNATURE—DO NOT PRINT) (DATE)

WARNING.—Any intentional 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.)

PART F

TO BE COMPLETED BY AGENCY.

1. NAME AND ADDRESS OF EMPLOYING OFFICE

HEALTH BENEFITS OFFICER

(SIGNATURE OF AUTHORIZED AGENCY OFFICIAL)

2. DATE RECEIVED IN EMPLOYING OFFICE 6/29/60
3. EFFECTIVE DATE OF ELECTION 7/10/60
4. PAYROLL OFFICE NO.
5. PAYROLL ACTION (INITIALS AND DATE) 9-1960

REMARKS

FOR USE ONLY BY ANNUITANTS AND AGENCY.

Original—To Payroll Office

APRIL 1960