

# Attachment 2

## Survey Participation Form

(Please complete a separate form for each plan or FEHB Sub-Code)

Plan Name: \_\_\_\_\_

FEHB Sub-Code: \_\_\_\_\_

**Please check the appropriate box(es) below:**

- Health Plan will conduct the CAHPS® 4.0H Adult Commercial Survey
- Health Plan will conduct the CAHPS® 4.0H Child Questionnaire (With CCC Measure)
- Health Plan will conduct the CAHPS® 4.0H Child Questionnaire (Without CCC Measure))
- Health Plan has fewer than 500 FEHB Subscribers/Contracts and will not conduct CAHPS® Surveys in 2010 for any reasons

**Name of NCQA Certified Survey Vendor that will be conducting the survey (s)**

**Survey Vendor Contact Information (Name, Address, E-Mail and Telephone Number):**

**Health Plan Contact: Name, Address, E-Mail and Telephone Number:**

**Plan Contact & Address for Invoice (if different from above):**

Please e-mail or fax the completed form by **February 1, 2010** to:

Angela M. Calarco email address: [angela.calarco@opm.gov](mailto:angela.calarco@opm.gov)

Fax #: (202) 606-0633

**(Please complete and return the form by February 1, 2010)**