Attachment 2

NOTICE OF INTENT TO DISENROLL

Name of Enrollee
Street Address
City, State and Zip

ID Number:
Social Security Number:

Dear {*name of enrollee*},

We are in the process of reconciling our Federal Employees Health Benefits (FEHB) enrollment records with the records of {*person's employing agency*}. Our records indicate that you are currently enrolled in our Health Benefits Plan through {*person's employing agency*}, but the information provided by {*person's employing agency*} does not show you as being enrolled in our Plan.

You must provide us with appropriate documentation verifying your current, valid enrollment with our Plan. You have 31 days from the date of this letter to provide us with this documentation. If we do not hear positively from you within the 31-day period, we will then disenroll you from our Plan. We will not disenroll you until the 31-day period expires. Appropriate documentation includes:

- A copy of your Standard Form 2809 (basic enrollment document) or Standard Form 2810 (notice of change in enrollment) demonstrating enrollment in this Plan;
- A copy of a letter confirming your electronic enrollment transaction such as Employee Express or the Annuitant Confirmation Letter that indicates your enrollment in this Plan;
- A copy of a recent earnings and leave statement, or annuity statement, showing withholding for this Plan; or
- A document or other credible information from your employing office or retirement system stating that you are entitled to continued enrollment in this Plan and that the premiums are being withheld.

Send or bring the appropriate documentation to:

{*Plan name and address, and phone number*}

If you are no longer enrolled in our Health Benefits Plan, please call and tell us. The reasons you might not be enrolled in our Plan include:

- You have changed your enrollment to another health plan;
- You have separated from Federal employment and are no longer eligible for FEHB enrollment; or
- You cancelled your enrollment.

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Please call the telephone number above and identify your current or former payroll office, so that we may contact them for any appropriate documentation.

Check the Social Security Number (SSN) shown above. If this is not your SSN, call us immediately and ask us to correct your number.

If we disenroll you and you believe we should not have disenrolled you, you may ask your employing office or retirement system to reconsider our decision. The request must be made in writing and must include your name, address, Social Security Number, Retirement Claim Number (if applicable), the name of this Plan, and the reason(s) for your request for reinstatement of your enrollment. The request for reconsideration must be filed within 60 calendar days from the date of this disenrollment notice.

If your employing office decides that you were improperly disenrolled, we will reinstate your enrollment retroactively. Any adjustment with respect to premiums and benefits will be determined by your employing office.

We regret any inconvenience this may cause you. If you have any questions, please call us at {*Plan phone number*}. Thank you.

Sincerely,