U.S. Department of State

EMPLOYEE STATEMENT CONCERNING FEHB COVERAGE DURING NONPAY STATUS

Name of Employee *(Last, First, MI)*	Today's Date *(mm-dd-yyyy)*
Social Security Number	Date of Birth *(mm-dd-yyyy)*
Enrollment Code *(from Earnings and Leave Statement)*	Effective Date of Nonpay Status *(mm-dd-yyyy)*

You must respond within 31 days *(45 days for employees residing overseas)* of this notice or your FEHB enrollment will automatically terminate.

Each pay period you are enrolled in the FEHB Program, you are responsible for payment of the employee share of the premium. When you enter nonpay status, or your pay is insufficient to cover the premium, you must elect one of the following:

- Terminate the enrollment; or
- Continue the enrollment and agree to pay the premium or incur a debt.

Please check the appropriate space below, sign to acknowledge receipt of this information and return this statement to your bureau Personnel Office.

☐ **I elect to terminate my health benefits enrollment**: I understand that I am entitled to an additional 31 days of temporary extension of coverage at no cost. During the 31 days, I may convert to a nongroup contract. I understand that such conversion is not automatic and that I must act on my behalf. When I return to pay and duty status, I will have 60 days to reenroll in FEHB coverage by completing **SF-2809**.

☐ **I elect to continue my health benefits enrollment for up to 365 days**: I understand that I must pay the premiums for my health benefits coverage which continues during nonpay status *(or during pay periods when my salary is insufficient to cover the required premiums).*

- ☐ **I will pay premiums directly.**
- ☐ **I will incur a debt.**

☐ **I have been called to active duty and elect to continue my health insurance**: I understand that the Department will pay the entire premium for up to 24 months.

If I elect to continue coverage, I must pay the premiums directly or incur a debt in the amount of the unpaid premiums. If I elect to pay directly, I will make a check or money order payable to Department of State.

Include on the check or money order, your name, social security number, a note that the payment is for "FEHB Premium", and mail to:
Department of State, Accounts Receivable Division, PO Box 979005, St, Louis, MO 63197-9000

PLEASE NOTE: If I elect to incur a debt, or if I elect to pay directly but fail to pay the entire amount due, I will receive a notice stating the total amount due. The notice will be sent when I return to pay status, my pay becomes sufficient, or I separate from employment. By electing to continue coverage, I agree to repay the resulting debt in full and to allow the debt to be collected by withholdings from any salary payments to me from the Federal Government. If the amount due cannot be withheld in full from salary, it will be recovered from a lump sum payment of accrued leave, income tax refunds, amounts payable under my retirement system, or any other source normally available for the recovery of a debt due the United States.

During nonpay status, I can be reached at the following:	
Address	
City/State/ZIP	
Telephone	Email Address

Acknowledgement: I have read and understand the conditions outlined above.

Signature	Date *(mm-dd-yyyy)*

Bureau or HR Service Provider - Distribution of Employee Statement Concerning FEHB Coverage During Nonpay Status (DS-5112) and Health Benefits Form (SF-2809 or SF-2810):

1. Forward signed and dated DS-5112 to PayIntake@state.gov
2. Forward signed and dated DS-5112 to OPF@state.gov for placement in the employee's Official Personnel File (eOPF)
3. If employee is terminating FEHB coverage, forward completed SF-2810 to HR Service Center at HRSC@state.gov
4. If applicable, forward completed SF-2809 to HR Service Center at HRSC@state.gov

Note: Please ensure the SF-50 is completed before forwarding the forms for processing.

Privacy Act Statement

AUTHORITY: The information is sought pursuant to the Federal Employees Health Benefits *(FEHB)* Program - Continuation of enrollment in nonpay status, 5 U.S.C. § 8906.

PURPOSE: To comply with the Federal Employees Health Benefits *(FEHB)* Program, which allows eligible employees to continue their health benefits while in nonpay status by choosing to either pay the employee share of their premiums directly or, incur a debt. The information furnished may also be used to certify that certain requirements are met.
The personal information including your SSN provided on this form is needed to document your enrollment in the Federal Employees Health Benefits Program *(FEHB)* under Part 89 of Title 5 of the United States Code.

EFFECTS OF NON-DISCLOSURE: Providing personal information, including your SSN and signing the LWOP Statement is voluntary, but failure to provide certain information may result in denial of health insurance benefits.