How to Use *PostalEASE* to Manage Your FEHB Enrollment

The *PostalEASE* telephone system and web sites provide a convenient, confidential, and secure way for you to newly enroll, change your current enrollment, or cancel your enrollment in the Federal Employees Health Benefits (FEHB) Program. If you have access to *PostalEASE* on the Internet *(https://liteblue.usps.gov),* at an Employee Self-Service Kiosk (available in some facilities), or on the Postal Service Intranet (from the Blue page), using either of these may be easier than using the telephone.

NOTE: Use your USPS Employee ID number (EIN) and USPS Self-Service Password (SSP) to access *LiteBlue*® and *PostalEASE*® via the web. Use your USPS EIN and current 4-digit USPS PIN to conduct self-service transactions on the telephone using Interactive Voice Recognition (IVR) . If you don't know your USPS Self-Service Password or USPS PIN, you can reset them using the Self-Service Profile Application at *www.ssp.usps.gov* or via links provided on Blue and on the LiteBlue logon page.

Through *PostalEASE* you may:

- Make a change to your current enrollment during FEHB Open Season.
- Make an election as a new employee within 60 days of your date of hire.
- Update your dependents' information for your Self Plus One and Self and Family enrollments.
- If you are making an enrollment change due to a qualifying life event (QLE), you will need to mail pages 3-5 to the Human Resources Shared Service Center (HRSSC).

Qualifying Life Event (QLE):

You cannot use *PostalEASE* to newly enroll, to change your enrollment, or to cancel or reduce your coverage due to a qualifying life event (QLE). You must contact the Human Resources Shared Service Center (HRSSC) to assist you with these actions.

If you are making an enrollment change due to a QLE, you will need to mail pages 3 - 5 to the Human Resources Shared Service Center (HRSSC).

If you are not making any changes to your current FEHB enrollment, then you do not need to do anything.

Preparing for PostalEASE FEHB Enrollment

1. **Read the Privacy Act Statement on page 5.**
2. **Read and understand** your health benefits information - available at ***https://liteblue.usps.gov/fehb.***
3. **Have the following information** ready before using *PostalEASE*.
   a. Your **Employee ID Number (EIN),** which is printed at the top of your earnings statement. Enter all 8 digits, even if the first number is a zero.
   b. Your **USPS Self-Service Password (SSP).** If you have forgotten your SSP, you can logon with your SSP Credentials and answer two security questions to get started in order to reset your password via the internet *(https://liteblue.usps.gov).* Click the "Forgot Your Password?" option. If you have not set up your password in the Self Service Profile application you may set one up through *https://ssp.usps.gov.* You may also request your password reset at an Employee Self-Service Kiosk (available at some facilities), or on the Intranet (from the Blue page) via the Human Resources website.
   c. **If accessing *PostalEASE* using the Employee Self-Service Line (1-877-477-3273, option 1)** you will also need your four-digit USPS PIN. You can reset a forgotten PIN by logging onto the Self-Service Profile application using the URL *https://ssp.usps.gov* and following the prompts or by contacting the Human Resources Shared Service Center on 1-877-477-3273, option 5. Enter your EIN and when prompted for your PIN, press 2. Your USPS PIN will be mailed to your address of record.
   d. Your daytime **phone number.**
   e. The **name of the health benefits plan** in which you are enrolling.
   f. The **enrollment code of the health benefits plan** in which you are enrolling**.** For the name and enrollment code, refer to *https://liteblue.usps.gov/openseason25* where you will find links to premiums and plan brochures.
   g. The names, Social Security Numbers, addresses, dates of birth, e-mail addresses and telephone numbers for all **eligible family members** that will be covered under your health benefits enrollment, including those who don't live with you. For more information on family member eligibility, go to *https://liteblue.usps.gov/fehb* where you will find the FEHB Program Guide.
   h. The name and policy number of any **other group insurance** you or any of your eligible family members may have (including TRICARE®, Medicare, etc.).
   i. If you are changing plans or canceling coverage, the **enrollment code** of the health benefits plan in which you are **currently enrolled —** that is, the plan that you will not have after your choice takes effect. The enrollment code for your current plan is found on your biweekly earnings statement. It is the three-character code that follows the letters "HP" or "HT." For example, the Blue Cross Self and Family Standard plan will be shown as HP105SLF or HT105FAM, and you will enter the code 105 in *PostalEASE*. You may also refer to health plan brochures on OPM's website *www.opm.gov/healthcare-insurance/healthcare/plan-information.*
4. **Complete the worksheet** on the following pages, using the information you prepared above.

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Now You Are Ready To Enroll

- If you have access to the *PostalEASE* Employee Web on the Internet *(https://liteblue.usps.gov),* at an Employee Self-Service Kiosk (available in some facilities), or on the Postal Service Intranet (from the Blue page), using these may be simpler than using the telephone. Just follow the instructions.
- Otherwise, call the Employee Service Line to reach *PostalEASE* toll-free at 1-877-4PS-EASE (1-877-477-3273, option 1) or 1-866-260-7507 for TTY.
- When prompted, select Federal Employees Health Benefits.
- Follow the script and prompts to enter your EIN, USPS PIN and information from your completed *PostalEASE* FEHB Worksheet.

After Completing Your Entries You Should Note the Following Information

- Record the confirmation number you receive from *PostalEASE:* _____
- Your enrollment will be processed on this date: _____
- Your enrollment will be reflected in your paycheck that is dated: _____

It is recommended that you keep this information and your *PostalEASE* FEHB Worksheet.

You may contact the Human Resources Shared Service Center (HRSSC) for assistance if:

- you are deaf or hard of hearing, or
- you cannot use the telephone, Internet, Employee Self Service kiosk or Intranet for a medical reason, or
- you receive a message in *PostalEASE* directing you to contact the HRSSC when attempting to make a change.

Just call the Employee Service Line at 1-877-477-3273. When prompted, select 5 for the HRSSC. Then select Benefits to speak with a representative who will assist you.

To reach the HRSSC using TTY, call 1-866-260-7507. Leave your name and email address or phone number where you can be reached along with a message indicating your call is regarding a *PostalEASE* related issue.

If you currently have an FEHB enrollment and you do not want to make any changes . . . ***do nothing.***

Dual enrollment is when you or an eligible family member under your Self Plus One or Self and Family enrollment are covered under more than one FEHB enrollment. No enrollee or family member may receive benefits under more than one FEHB enrollment.

If you or a family member receives benefits under more than one plan, it is considered fraud and you are subject to disciplinary action.

WARNING: Additionally, any intentionally false statement or willful misrepresentation in your application for Federal Employees Health Benefits coverage is a violation of the law and 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)

PostalEASE FEHB Worksheet

Changes due to a qualifying life event (QLE) cannot be made via PostalEASE

This worksheet will help you prepare to call *PostalEASE,* or use *PostalEASE* on the Internet *(https://liteblue.usps.gov),* on an Employee Self-Service Kiosk (now available in some facilities) or on the Postal Service Intranet (from the Blue page). You may contact the Human Resources Shared Service Center (HRSSC) by calling 1-877-477-3273, Option 5 or TTY, 1-866-260-7507 for assistance if:

- you are deaf or hard of hearing or
- you cannot use the telephone, Internet, Employee Self Service kiosk or Intranet for a medical reason or
- you receive a message in *PostalEASE* directing you to contact the HRSSC when attempting to make a change.

Please Note:

- You will need to **provide documentation** if your election is due to a QLE and that you are contacting the HRSSC within the required time frame.

For more information on QLEs, please refer to *https://liteblue.usps.gov/qle4*

Except for open season and adding eligible family members, most enrollments and changes of enrollment are effective on the first day of the pay period after receipt of this form at the HRSSC. The HRSSC can give you the specific date on which your enrollment or enrollment change will take effect.

Part 1 — Employee Information

☐ Career ☐ Non-career

Your Name *(Last, First, Middle Initial)*	Employee ID

Your Gender: ☐ Male ☐ Female	**Married:** ☐ Yes ☐ No	**Daytime Telephone Number** (including area code) **Email address:**

Your Other Group Insurance *(Not used for waiving enrollment as a new employee).*

1) Are you covered by insurance other than Medicare?

☐ Yes ☐ No

If YES, indicate type of other insurance in item 2.

2) Identify Type of Other Insurance Coverage

☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D

☐ TRICARE ☐ OTHER_____

Other Insurance Policy No. _____

(No person may be covered under more than one FEHB enrollment.)

Part 2 — Type of Action You Are Requesting

1) Open Season: ☐ New Enrollment ☐ Change Current Enrollment ☐ Cancel Enrollment

2) New Hire: ☐ New Enrollment ☐ Waive Enrollment

3) QLE or Special Enrollment

☐ New Enrollment ☐ Cancel Enrollment

☐ Change Current Enrollment ☐ Update Dependent List Only
If updating dependent list complete parts 4–7

☐ Waive Enrollment

Type of QLE Actions

In most cases enrollment must be received at the HRSSC within 60 days after the QLE

Marriage: _____ (Date)
Divorce: _____ (Date)
Birth of Child: _____ (Date)
Dependent Death: _____ (Date)
Other: _____(Date)

Part 3 — Enrollment Plan Name And Plan Code

1) New Plan Name:

2) New Enrollment Code: _____

☐ Self Only ☐ Self Plus One ☐ Self and Family

3) Old Plan Enrollment Code *(if you are changing plans or canceling your current plan)*

PostalEASE FEHB Worksheet

Employee Name: _____ **EIN:** _____

Part 4 — Dependent Information *(for Self Plus One and Self and Family coverage only)*

A complete mailing address (if different from the USPS employee's) and other insurance information, if any, must be provided for each covered dependent.

1) ☐ **Please check here if all dependents reside with you. No person may be covered by more than one FEHB enrollment.**

2) Complete the following information for each dependent

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship Code*

Address *(if different from enrollee)*

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

If covered by Medicare, check all that apply ☐ A ☐ B ☐ D

Medicare Claim Number

Is this family member covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No

Indicate the type(s) of other insurance:

☐ FEHB ☐ TRICARE ☐ Other Name of other insurance: _____ Policy Number: _____

Email address *(if home address is different from enrollee's)*

Preferred telephone number *(if home address is different from enrollee's)*

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship Code*

Address *(if different from enrollee)*

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

If covered by Medicare, check all that apply ☐ A ☐ B ☐ D

Medicare Claim Number

Is this family member covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No

Indicate the type(s) of other insurance:

☐ FEHB ☐ TRICARE ☐ Other Name of other insurance: _____ Policy Number: _____

Email address *(if home address is different from enrollee's)*

Preferred telephone number *(if home address is different from enrollee's)*

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship Code*

Address *(if different from enrollee)*

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

If covered by Medicare, check all that apply ☐ A ☐ B ☐ D

Medicare Claim Number

Is this family member covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No

Indicate the type(s) of other insurance:

☐ FEHB ☐ TRICARE ☐ Other Name of other insurance: _____ Policy Number: _____

Email address *(if home address is different from enrollee's)*

Preferred telephone number *(if home address is different from enrollee's)*

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship Code*

Address *(if different from enrollee)*

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

If covered by Medicare, check all that apply ☐ A ☐ B ☐ D

Medicare Claim Number

Is this family member covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No

Indicate the type(s) of other insurance:

☐ FEHB ☐ TRICARE ☐ Other Name of other insurance: _____ Policy Number: _____

Email address *(if home address is different from enrollee's)*

Preferred telephone number *(if home address is different from enrollee's)*

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship Code*

Address *(if different from enrollee)*

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

If covered by Medicare, check all that apply ☐ A ☐ B ☐ D

Medicare Claim Number

Is this family member covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No

Indicate the type(s) of other insurance:

☐ FEHB ☐ TRICARE ☐ Other Name of other insurance: _____ Policy Number: _____

Email address *(if home address is different from enrollee's)*

Preferred telephone number *(if home address is different from enrollee's)*

***Relationship Codes: 01 –** Legal Spouse, **02 –** Common Law Spouse (certification required), **09 – Adopted Child (adoption decree needed)** Under Age 26, **10 –** Foster Child Under Age 26 (certification required), **17 –** Stepchild,**19 –** Biological Child, **99 –** Child age 26 or Older Incapable of Self-Support (medical documents required)

PostalEASE FEHB Worksheet

Part 5 —

Employee Signature _____ **Date** _____

Email Address _____ **Preferred telephone number** _____

Acknowledgment for Non-career Employees

I acknowledge that I have researched the health plan information for my service area and I am aware of the bi-weekly premium for the plan that I've chosen. I understand that if I am not eligible for a USPS contribution, I will be responsible for 100% of the premium cost.

I understand that I must pay any invoice issued by the Eagan ASC for health benefits premium costs within 30 days of the date the invoice was issued. I further understand that if I fail to pay the invoice within the specified time, my health benefits enrollment under FEHB will be terminated retroactive to the date the initial unpaid premium was due. As a result, I will be liable to the insurance carrier and/or health care provider for any medical expenses I have incurred since the date of termination.

For HRSSC Use Only

REMARKS: *Specific information on type of qualifying life event, reason for correction, type of certification, supporting documentation, reason for verification, etc., should be provided here.*

Processing NOTES:

Employing Office:	**HRSSC COMP & BENEFITS**	LATE/UNPROCESSED ACTION? ☐ Yes ☐ No	
Address:	**PO BOX 970400**	DATE RECEIVED at HRSSC:	
City/State/ZIP Code:	**GREENSBORO NC 27497-0400**	QLE DATE:	
PROCESSED BY:	PPS @ HRSSC	EFFECTIVE DATE:	
Date Scanned To Eagan:		File copy in OPF for any FEHB transaction processed by HRSSC and ASC	

Privacy Act Statement: Your information will be used to process your enrollment in the Federal Employees Health Benefits system and to manage your claim under that plan. Collection is authorized by 39 U.S.C. 401, 409, 410, 1001, 1003, 1004,1005, and 1206 and 1206; and 29 U.S, 2601 et seq.

Providing the information is voluntary, but if not provided, we may not process your request. We may disclose your information as follows: in relevant legal proceedings; to law enforcement when the U.S. Postal Service (USPS) or requesting agency becomes aware of a violation of law; to a Congressional office at your request; to entities or individuals under contract with USPS; to entities authorized to perform audits: to labor organizations as required by law; to federal, state, local or foreign government agencies regarding personnel matters; to the Equal Employment Opportunity Commission; to the Merit Systems Protection Board or Office of Special Counsel; the Selective Service System, records pertaining to supervisors and postmasters may be disclosed to supervisory and other managerial organizations recognized by USPS; and to financial entities regarding financial transaction issues.

OPM Privacy Act and Paperwork Reduction Act Notice: The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program under Chapter 89, title 5, U.S. Code. The principle use of this information will be to share it with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. Other routine uses include disclosures to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. May also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or Social Security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency. While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment. We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB Program, and for other purposes. Executive Order 13478 (November 18, 2009) allows Federal agencies to use the Social Security Number as individual identifiers to distinguish between people with the same or similar names. Failure to furnish your Social Security Number and/or Medicare Claim Number may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies, proper coordination with Medicare and proper health insurance status reporting to the IRS.

Public Burden Statement: We think this form takes an average of 30 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, OPM Forms Officer, (3206-0160), Washington, D.C. 20415-3430. The OMS number 3206-0160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.