- Make new hanging file called "enrollment forms"

Thrift Savings Plan

Open Season
- May 15 - July 31
- new employees must sit through one open season before they are eligible to enroll
- next open season - Nov. 1993

Health Benefits

- Next Open Season
  November 1993
  (Michelle Joy) x 5890

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1993 Enrollment information & Plan Comparison Chart

1992 Open Season for

Federal civilian employees

FEHB
Federal Employees Health Benefits Program

What's inside:

United States Office of Personnel Management

Retirement and Insurance Group
1900 E Street, NW
Washington, DC 20415-0001

RI 70-1
Rev. November 1992

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UNICOR FEDERAL PRISON INDUSTRIES INC.
LEAVENWORTH KANSAS

THRIFT SAVINGS PLAN
ELECTION FORM

TSP-1

Use this form to:
- Start or change your contributions to the Thrift Savings Plan (TSP)
- Stop your contributions to the TSP
- Indicate how you want your future contributions to be invested in the three TSP Funds

Before completing this form, please read the *Summary of the Thrift Savings Plan for Federal Employees* and the instructions on the back of this form. Type or print all information. **Return the completed form to your agency employing office.** Do not remove your copy. Your agency will return it to you after completing Section VII.

I. INFORMATION ABOUT YOU

1. _____
Name *(Last)* *(First)* *(Middle)*

2. _____
Street Address City State Zip Code

3. _____
Social Security Number

4. ( ) _____
Daytime Phone *(Area Code and Number)*

5. _____
Date of Birth *(Month/Day/Year)*

6. _____
Office Identification *(Agency and Organization)*

II. AMOUNT OF YOUR CONTRIBUTIONS

If you complete this section, you must also complete Section IV

Complete either Part A or Part B of this section.

Part A. To contribute to your TSP account, enter **either** a whole percentage of your basic pay per pay period (Item 7) **or** a whole dollar amount per pay period (Item 8).

Part B. If you are a FERS employee who is not, and will not be, contributing to your TSP account at this time, but you are allocating your Agency Automatic (1%) Contributions, check Item 9.

7. _____.0% **OR** 8. $ _____.00 9. ☐ (Noncontributing FERS)

III. STOPPING YOUR CONTRIBUTIONS

Do not complete Section II. FERS employees must also complete Section IV

To stop your contributions to the TSP, check Item 10 and sign and date Items 15 and 16. If you are a FERS employee, your Agency Automatic (1%) Contributions will continue. You must complete Section IV to show how you want these contributions to be divided among the three TSP Funds.

10. ☐ I want to stop contributing to my TSP account. I understand that my payroll deductions will stop at the end of the pay period in which my agency employing office accepts this form.

IV. ALLOCATING CONTRIBUTIONS

You must also complete Section II or III

Show how you want future contributions to your account to be divided among the G, F, and C Funds. Enter the percentage (in multiples of 5%) that you want invested in each Fund. Do not use dollar amounts. The total of Items 11, 12, and 13 must equal 100%. If you are a FERS employee, the percentages that you choose will be applied to all contributions to your account, including Agency Automatic (1%) Contributions and Agency Matching Contributions.

If you invest in either the F or C Fund, you must sign Item 14; otherwise, your form will be returned to you unprocessed.

11. **G Fund**	Government Securities Investment Fund	_____.0%
12. **F Fund**	Fixed Income Index Investment Fund	_____.0%
13. **C Fund**	Common Stock Index Investment Fund	_____.0%
	Total	100.0%

V. ACKNOWLEDGEMENT OF RISK

Also sign Section VI

I have chosen to invest in the F and/or C Fund. I understand that I am making this investment at my own risk. I also understand that I am not protected by either the U.S. Government or the Federal Retirement Thrift Investment Board against investment loss in the F or C Fund, and that neither the U.S. Government nor the Federal Retirement Thrift Investment Board guarantees a return on my investment.

14. _____
Participant's Signature

VI. SIGNATURE

You must sign Item 15 and date Item 16; otherwise, your form will be returned to you unprocessed.

15. _____ 16. _____
Participant's Signature Date Signed

VII. FOR EMPLOYING OFFICE USE ONLY

17. _____ 18. _____ 19. _____ 20. _____
Payroll Office Number Agency Code Effective Date TSP SCD (Optional)

21. _____ 22. _____
Signature of Employing Office Official Acceptance Date

23. _____ 24. _____
New Eligibility Date if Item 10 Is Checked Remarks

PART 1 — OFFICIAL PERSONNEL FOLDER—ORIGINAL

Form TSP-1 Revised 2/91

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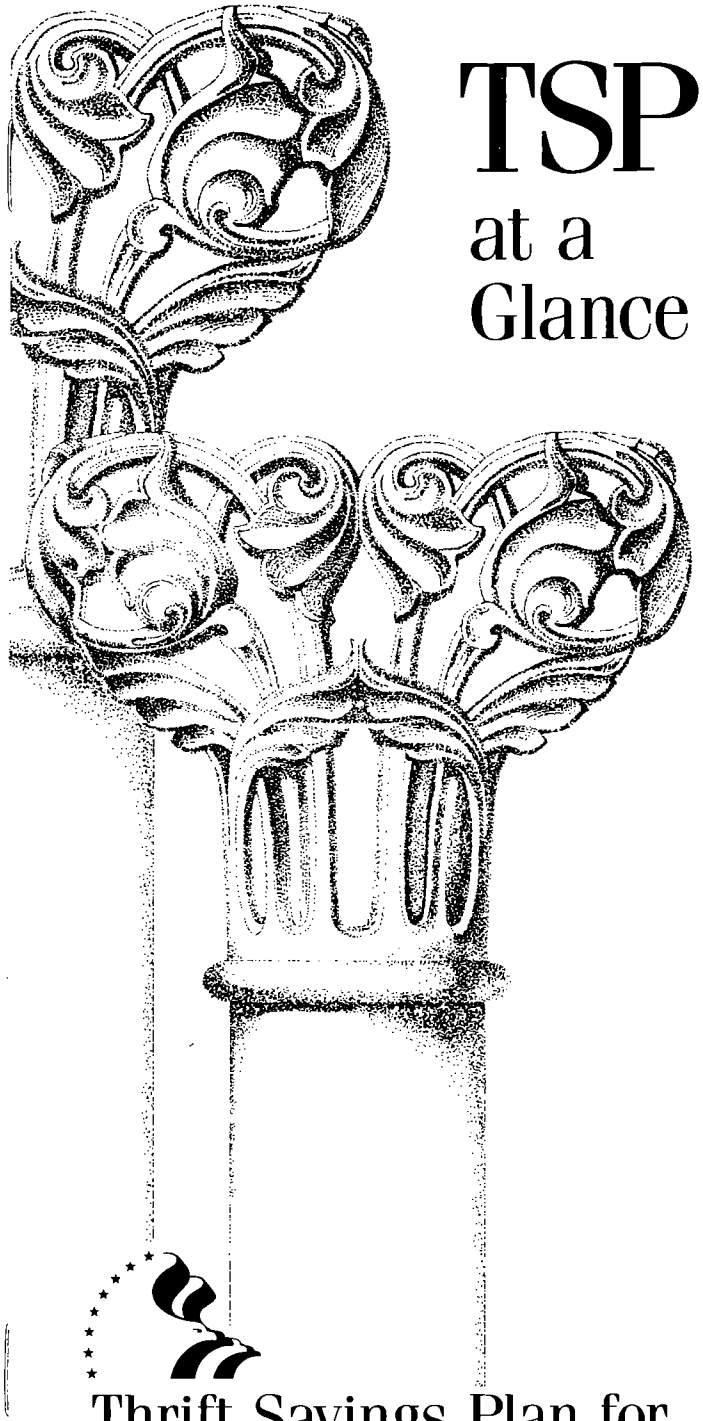
Thrift Savings Plan for Federal Employees



TSP at a Glance

Thrift Savings Plan for Federal Employees

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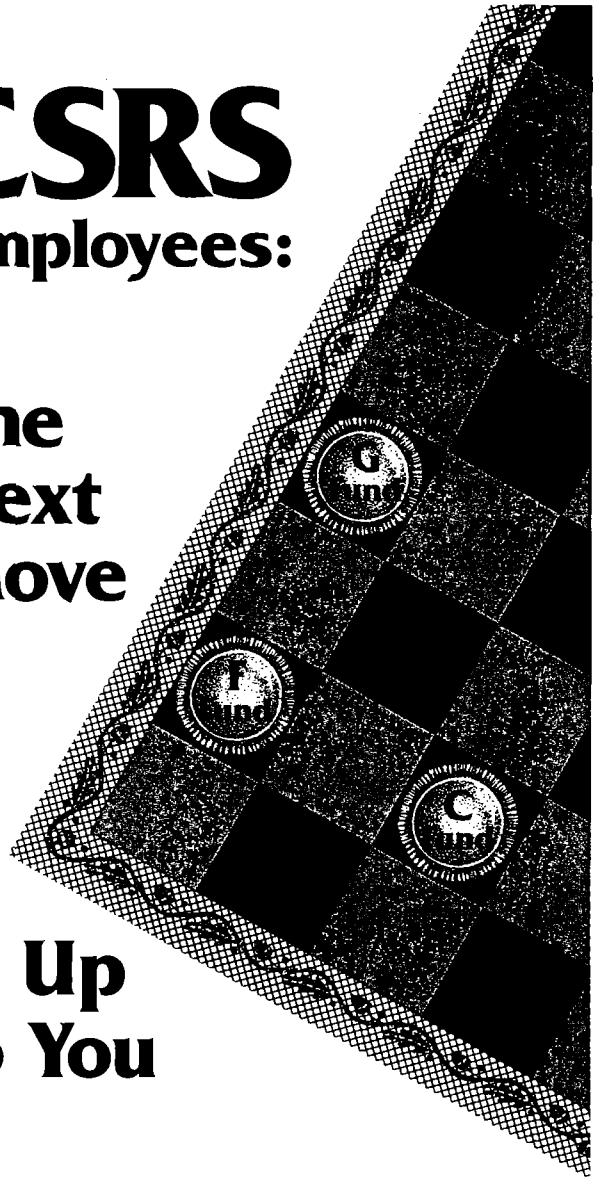
CSRS Employees: The Next Move
Is Up to You.

CSRS Employees:

The Next Move



Is Up to You

The Thrift Savings Plan for Federa Employees

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Loan Program
Federal Retirement Thrift
Investment Board
January 1993

Thrift Savings Plan

Loan Program

Federal Retirement
Thrift Investment Board

January 1990

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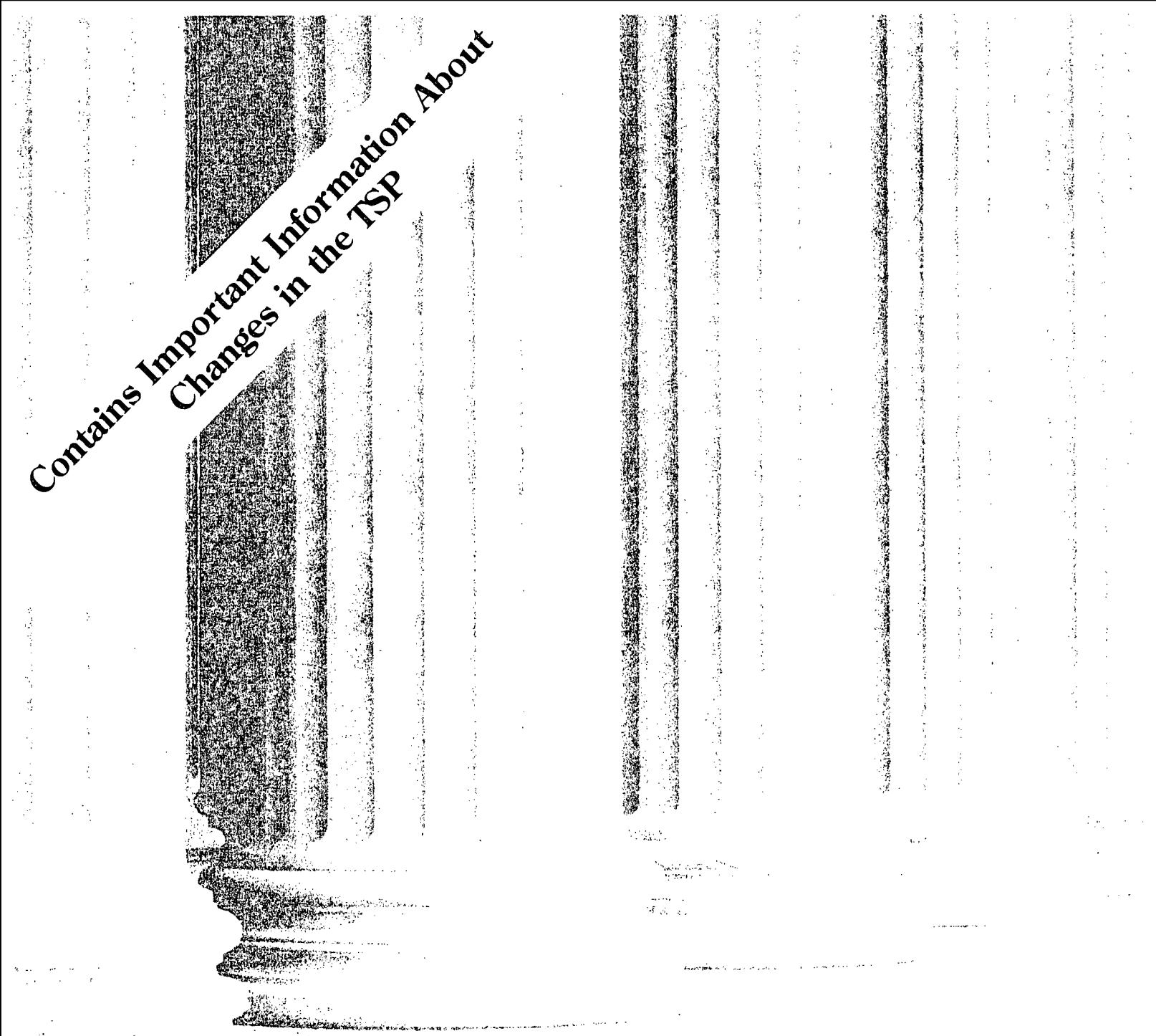

Contains Important Information About Changes in the TSP

SUMMARY OF THE

THRIFT SAVINGS PLAN

FOR FEDERAL EMPLOYEES

SEPTEMBER 1990

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Federal Employees Health Benefits Program

Standard Form 2809
Rev. August 1992

Form Approved.
OMB No. 3206-0160

Health Benefits Registration Form

Uses for Standard Form (SF) 2809

Use this form to:

- Enroll in the FEHB Program; or
- Elect not to enroll in the FEHB Program (employees only); or
- Change your FEHB enrollment from Self Only to Self and Family and/or from your present plan or option to another plan or option because of an event described in the Table on page 6; or
- Change your FEHB enrollment from Self and Family to Self Only; or
- Cancel your FEHB enrollment.

Who May Use SF 2809

1. Employees eligible to enroll in or currently enrolled in the FEHB Program, including temporary employees eligible under 5 U.S.C. 8906a.
2. Annuitants (other than CSRS/FERS annuitants) eligible to enroll in or currently enrolled in the FEHB Program, including individuals receiving monthly compensation from the Office of Workers' Compensation Programs.

*Note: CSRS/FERS annuitants -- **Do not use this form.** To obtain the appropriate form, write to:*

Office of Personnel Management
Insurance Services Branch
P.O. Box 14172
Washington, D.C. 20044

3. Former spouses eligible to enroll in or currently enrolled in the FEHB Program under the Spouse Equity Act or similar statutes.
4. Individuals eligible for temporary continuation of coverage under the FEHB Program, including:
   - Former employees (who separated from service);
   - Children who lose FEHB coverage; and
   - Former spouses who are not eligible for FEHB under item 3 above.

*Note: Former spouses and children of CSRS/FERS annuitants -- **Do not use this form.** To obtain the appropriate form, write to address shown in item 2 above.*

Instructions for Completing SF 2809

Type or Print Firmly

PART A. You must complete this part.

Item 1. Give your last name, first name and middle initial.

Item 2. Enter your Social Security Number. (See Privacy Act Statement on Page 5.)

Item 3. Give your date of birth, using numbers to show the month, day and year

Item 4. Enter your permanent home mailing address.

Item 5. Place an "X" in the appropriate box.

Item 6. Place an "X" in the box that signifies your current marital status (if you are separated but not divorced, you are still married).

Item 7. Give your telephone number where you can be reached during normal business hours. Be sure to include the area code.

PART B. Complete this part to enroll or change your enrollment in the FEHB Program. (If you are changing your enrollment, also complete PART C.)

Item 1. Enter the plan name and appropriate enrollment code from the back cover of the brochure of the plan you want to enroll in or change to. (The enrollment code identifies the plan and option you are electing and whether you are electing Self Only or Self and Family.) If you are just changing from one option to another within a plan, for example, from Self Only to Self and Family or from Self and Family to Self Only, enter the name of your present plan and the new enrollment code.

If the plan you want is a prepaid plan (CMP/HMO), be sure you live in the plan's enrollment area. If it is an employee organization plan, be sure you are eligible to enroll in the plan; you must be or become a member of the plan's sponsoring organization.

Your signature in Part D authorizes deductions from your salary, annuity, or compensation to cover your cost of the enrollment you elect in this item, unless you are required to make direct payments to the employing office.

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HEALTH BENEFITS REGISTRATION FORM

Federal Employees Health Benefits Program

Form Approved: OMB No. 3206-0160

- Complete Part A and Parts B, C, D, and E as applicable.
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- Type or Print Firmly.
- Sign and date in Part F.

PART A - *Fill in this part.*

1. Name *(Last, first, middle initial)*	2. Social Security number	3. Date of birth *(mo., day, yr.)* / /
4. Your home mailing address *(include ZIP code)*	5. Sex ☐ Male ☐ Female	6. Are you now married? ☐ Yes ☐ No
	7. Daytime telephone number ( )	

PART B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of plan — Enrollment code ▶

2a. Names of family members	2b. ZIP code	2c. Date of birth *(mo., day, yr.)*	2d. Sex	2e. Relationship "code"	2f. Social Security number *(See Instructions)*
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			

3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? ☐ No ☐ Yes → Complete 3b

3b. Type of insurance ▶ Medicare ☐ No ☐ Yes → *Indicate part(s)* ☐ CHAMPUS ☐ Other private *(specify name)*

PART C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name	2. Present Plan enrollment code ▶	3. Number of event that permits change *(See Table of Permissable Changes)*	4. Date of event that permits change *(mo., day, yr.)* / /

PART D - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART F certifies that I have read and understand the information regarding this election.

PART E - *CANCELLATION*

Place an "X" in the box below if you wish to CANCEL your enrollment.

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right.

Present Plan enrollment code

My signature in PART F certifies that I have read the information in the instructions regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

PART F - *Fill in this part.*

WARNING: Any intentionally 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.)

1. Your signature *(Do not print)*	2. Date

PART G - *To be completed by agency*

1. Name and address of employing office	2. Date received in employing office	3. Effective date of action	4. SF 2811 report number
	5. Payroll office number	6. Payroll contact and telephone number ( )	
	7. Personnel contact and telephone number ( )		
	8. Signature of authorized agency official	9. Phone number ( )	

Remarks