Federal Employees 2026

Physician Selection and Dental Enrollment Form

How to Enroll:

(1) Simply complete the Health Benefits Registration Form (SF 2809) available from your personnel office. (2) Please complete this form and return it to us in the enclosed self-addressed stamped envelope. For Employee Express, visit www.opm.gov/insure.

(3) To enroll in the supplemental dental program, complete the dental program section of this form.

Name: First	Last	M.I.	FOR OFFICIAL USE ONLY:
			GROUP NO:
Date of Birth	☐ Male ☐ Female	Social Security Number	COVERAGE:
			EFFECTIVE DATE:

Mailing Address: Street	City	Zip Code	Home Phone	Business Phone

Employing Agency	Date of Hire

For my medical coverage, I will be enrolling for:	Have you previously been an HPN member? If yes,	Have you previously enrolled in the Supplemental Dental Program?
☐ Self ☐ Self + One ☐ Self & Family	☐ Yes member ☐ No number	☐ Yes ☐ No

Do you or your spouse have any other group coverage? ☐ Yes ☐ No	Name of Insurance Company
Policy Holder	Name of Group

Supplemental Dental Program:

Please enroll me in the HPN Supplemental Dental Plan:
Dental benefits are renewed on a calendar year basis each January.
Payment must be submitted by January 31st. ☐ Self ($100.00/yr.) ☐ Self + One ($200.00/yr.) ☐ Self + Family ($350.00/yr.)

REMEMBER: You must include a check for the full annual dental premium if enrolling.

Employee Information:

Employee Name: First	Last	M.I.	☐ Male ☐ Female	Date of Birth	Social Security Number

Physician Code*	OB/GYN Code*

Is the above Medicare eligible? ☐ Yes ☐ No	If yes, ☐ A ☐ B ☐ Both A & B	Medicare Claim Number

Please enroll the following dependents:

Spouse Name: First	Last	M.I.	☐ Male ☐ Female	Date of Birth	Social Security Number

Physician Code*	OB/GYN Code*

Is the above Medicare eligible? ☐ Yes ☐ No	If yes, ☐ A ☐ B ☐ Both A & B	Medicare Claim Number

Child Name: First	Last	M.I.	☐ Male ☐ Female	Date of Birth	Social Security Number
Physician Code*		OB/GYN Code*			
Is the above Medicare eligible?	☐ Yes ☐ No	If yes, ☐ A ☐ B	☐ Both A & B	Medicare Claim Number	
Child Name: First	Last	M.I.	☐ Male ☐ Female	Date of Birth	Social Security Number
Physician Code*		OB/GYN Code*			
Is the above Medicare eligible?	☐ Yes ☐ No	If yes, ☐ A ☐ B	☐ Both A & B	Medicare Claim Number	
Child Name: First	Last	M.I.	☐ Male ☐ Female	Date of Birth	Social Security Number
Physician Code*		OB/GYN Code*			
Is the above Medicare eligible?	☐ Yes ☐ No	If yes, ☐ A ☐ B	☐ Both A & B	Medicare Claim Number	
Child Name: First	Last	M.I.	☐ Male ☐ Female	Date of Birth	Social Security Number
Physician Code*		OB/GYN Code*			
Is the above Medicare eligible?	☐ Yes ☐ No	If yes, ☐ A ☐ B	☐ Both A & B	Medicare Claim Number	

* Refer to your provider directory and enter the number found next to the physician you choose for each option.
If you are a female, please choose a primary care provider and an OB/GYN.

Employee signature	Date	Employer

Health Plan of Nevada
A UnitedHealthcare Company