



**Your Name**

**Part A. Information about the insured**

1. Insured's full name <i>(Last) (First) (Middle)</i>	2. Date of birth <i>(mm/dd/yyyy)</i>	3. Date of death <i>(mm/dd/yyyy)</i>
4. Social Security number or FEGLI Claim number	5. Legal Residence at time of death <i>(City and State)</i>	
6. Department or agency in which last employed, including bureau or division	7. Location of last employment <i>(City, State, ZIP Code)</i>	
8. At the time of death, was the insured retired under any Federal civilian retirement system?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <span style="float: right; margin-left: 20px;">If "Yes", provide the Claim number <i>(CSA/CSF/CSI)</i></span>		
9. At the time of death, was the insured receiving Federal Worker's Compensation benefits?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <span style="float: right; margin-left: 20px;">If "Yes", provide the effective date of Federal Worker's Compensation Benefits</span>		

**Part B. Information about the insured's marriages**

1. How many times was the insured married? <i>Include yourself if you were married to the insured at the time of death.</i>	2. Give the name of each spouse <i>(include ALL marriages)</i>	3. How did the marriage end? <i>(Check one in each case)</i>	4. When did the marriage end? <i>(mm/dd/yyyy)</i>
		<input type="checkbox"/> Death <input type="checkbox"/> Divorce	
		<input type="checkbox"/> Death <input type="checkbox"/> Divorce	
		<input type="checkbox"/> Death <input type="checkbox"/> Divorce	
		<input type="checkbox"/> Death <input type="checkbox"/> Divorce	

**Part C. Information about your marriages**  
*(Complete only if you are the insured's widow or widower)*

1. Date of marriage <i>(mm/dd/yyyy)</i>	2. Place of marriage <i>(City and State)</i>	3. Marriage was performed by: <input type="checkbox"/> Clergy or Justice of the Peace <input type="checkbox"/> Other <i>(specify)</i>	
4. Were you divorced from the insured at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. If you were divorced from the insured, give the date (mm/dd/yyyy) and place of divorce			
6. How many times were you married? <i>Include the insured if you were married at the time of death.</i>	7. Give the name of each spouse <i>(include ALL marriages)</i>	8. How did the marriage end? <i>(Check one in each case)</i>	9. When did the marriage end? <i>(mm/dd/yyyy)</i>
		<input type="checkbox"/> Death <input type="checkbox"/> Divorce	
		<input type="checkbox"/> Death <input type="checkbox"/> Divorce	
		<input type="checkbox"/> Death <input type="checkbox"/> Divorce	
		<input type="checkbox"/> Death <input type="checkbox"/> Divorce	

**Part D. Information about the insured's next of kin**  
*(Everyone must complete Part D unless you are the insured's widow or widower)*

1. Did the insured have any living children on the date of his/her death?  Yes  No\* If Yes, how many \_\_\_\_\_

Please list the insured's living children below. Note that step-children are not eligible.

\*(a) If the insured has no children, list the insured's parents; if one or both parents died before the insured, provide their name(s) and date(s) of death.

(b) If the insured has no children, and both parents died before the insured, list the next of kin who may be capable of inheriting from the insured (*brothers, sisters, descendants of deceased brothers, sisters, etc.*). Additional sheets can be used if needed.

Name	Age	Relationship to the insured	Full address

2. Did the insured have any children who died before his/her date of death?  Yes  No If Yes, how many \_\_\_\_\_

Please list any children who died before the insured. If any of the children who died before also have children (descendants), list them below as well and indicate the parent who was the insured's child. Additional sheets can be used if needed.

Name	Age	Relationship to the insured	Full address
		<input type="checkbox"/> Child <input type="checkbox"/> Descendant	
		<input type="checkbox"/> Child <input type="checkbox"/> Descendant	
		<input type="checkbox"/> Child <input type="checkbox"/> Descendant	
		<input type="checkbox"/> Child <input type="checkbox"/> Descendant	
		<input type="checkbox"/> Child <input type="checkbox"/> Descendant	
		<input type="checkbox"/> Child <input type="checkbox"/> Descendant	

**Complete item 3 only if any of the persons listed above are under age 18**

3. If the court appointed a guardian for the estate of any minor children above, give the name and address of the guardian and attach a copy of the court appointment papers. Natural parentage or custody as a result of a divorce do not constitute guardianship.

Name		
Address (number, street, apt. no.)		
City	State	ZIP Code

**Part E. Information about the insured's estate (Complete if the insured's estate is entitled)**

If the court appointed an executor or administrator to settle the insured's estate, give his/her name and address and attach a copy of the court appointment papers.

Name		
Address (number, street, apt. no.)		
City	State	ZIP Code

**Part F. Additional information**

Have you signed a document with a funeral home that authorizes us to make a payment directly to them?  Yes  No  
 This document is usually referred to as a funeral home assignment. (If yes, please send us a copy of the document with this claim form.)

Are you claiming accidental death benefits (*did the insured die solely through violent, external, and accidental means*)? If "Yes", submit coroner's and police reports, news clippings, and any other available reports concerning the accident. OFEGLI cannot consider a claim for such benefits if the insured separated or retired before the accident.  Yes  No



**Part G: Select a method to receive your payment**

Please **SELECT ONE** method of settlement in order to receive your payment. By selecting below, you confirm that you have read the enclosed materials on both FEGLI payment options.

**Total Control Account (TCA)**

**Check**

*FEGLI death benefits are not subject to Federal income tax, but the interest that OFEGLI pays on those benefits is subject to such tax. OFEGLI will report all interest payments to the Internal Revenue Service (IRS).*

**Part H - Information about you**

*Please note: If you are completing this claim on behalf of someone else (such as a minor), complete all of Part H with that person's information, and not yours. Sign your own name "on behalf of" the other person.*

<b>Name (please print)</b>	<b>Relationship to the insured</b>	<b>Date of birth</b>
<b>Address (number, street, apartment number)</b>		
<b>City</b>	<b>State</b>	<b>ZIP</b>
<b>Social Security number</b>	<b>or</b>	<b>Estate/Trust/Tax ID Number</b>
<b>Daytime Telephone number</b>	<b>Email address</b>	

**Under penalties of perjury, I certify:**

1. That the number shown as my Social Security Number in "Part H: Information about you" is my correct taxpayer identification number, and
  2. That I am NOT subject to backup withholding because: (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends, or (b) I am exempt from backup withholding, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
  3. I am a U.S. citizen, resident alien, or other U.S. person\*, and
  4. I am not subject to Foreign Account Tax Compliance Act (FATCA) reporting because I am a U.S. person\* and the account is located within the United States.
- (Please note: You must cross out Item 2 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest or dividend income on your tax return.)*
- \* If you are not a U.S. Citizen, a U.S. resident alien or other U.S. person for tax purposes, please cross out Item 3 above, and complete form W-8BEN (individuals) or W-8BEN-E (entities).  
The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.



**Signature** If you are completing this claim on behalf of someone else sign your own name "on behalf of" the other person. **Today's Date**

**Warning** - If you knowingly and willfully make any materially false, fictitious, or fraudulent statement or representation on this form, or conceal a material fact related to the requests for information on this form, you may be subject to a monetary fine or imprisonment for not more than five years, or both under 18 U.S.C. 100

**Please return pages 3 through 5 to OFEGLI**