Office of Federal Employees' Group Life Insurance
200 Park Avenue
New York, NY 10166-0188

FEGLI

Statement of Claim
Option C—Family Life Insurance
Federal Employees' Group Life Insurance

Read instructions on the reverse side of this form before completing form.

Part A—General Information About the Insured

1. Name of Insured *(Last, first, middle) (Type or Print)*	2. Date of birth *(Month, day, year)*	3. Social Security Number

4. Department or agency in which employed (include bureau or division)	5. Location of employment *(City, State, Zip Code)*

6. Are you retired and receiving annuity under any Federal civilian retirement system, including old age and survivors insurance (Social Security)?

☐ Yes, Give → ☐ No

6a. Retirement claim number	6b. Date of retirement

Part B—Information About Deceased Family Member

1. Full name of deceased	2. Date of birth *(Month, day, year)*	3. Date of death *(Month, day, year)*

Complete blanks 4-7 if deceased is your SPOUSE

4. Date of marriage *(Month, day, year)*	5. Place of marriage *(City, State)*	6. Marriage was performed by ☐ Clergy or Justice of the Peace ☐ Other *(Specify)*

7. Was this marriage ended by divorce?

☐ Yes, Give → ☐ No

7a. Date of divorce *(Month, day, year)*	7b. Place of divorce *(City, State)*

Complete blanks 8-11 if deceased is your CHILD

8. Child's marital status
☐ Single ☐ Married

9. Child's relationship to you
☐ Legitimate child ☐ Stepchild ☐ Disabled dependent child 22 yrs. or over *(attach documentation)*
☐ Adopted child ☐ Recognized natural child ☐ Other *(Specify)*

10. If the deceased was a stepchild or recognized natural child, was the child living with you at the time of death? ☐ Yes ☐ No *(Explain on separate sheet)*	11. If the deceased was a recognized natural child and was not living with you at the time of death, did you provide financial support for the child? ☐ Yes ☐ No *(Explain on separate sheet)*

Part C—Certification By the Insured

1. **Backup Withholding** Have you been notified by the IRS that you are subject to backup withholding as a result of a failure to report all interest or dividends? ☐ Yes ☐ No	2. Signature of insured *(Do not print)*
I hereby certify that all statements made in this claim are true to the best of my knowledge, information, and belief, and that no evidence necessary to a settlement of this claim is suppressed or withheld.	3. Full name of insured *(Type or Print)*
	4. Mailing address *(Number, street, apt. no.)*
Warning: Any intentional false statement in the claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)	5. City, State and Zip code
	6. Date *(Month, day, year)* / 7. Telephone number *(incl. area code)*

Part D—Certification of Insurance Status

ACTIVE Employees — to be completed by employing agency
FORMER Employees who are RETIREES or COMPENSATIONERS — to be completed by the Office of Personnel Management

1. Did employee have Option C-Family Insurance on the date of death of the family member? ☐ Yes, Give → ☐ No	1a. Effective date of election	2. If employee is retired or receiving compensation, complete Boxes 2a. and 2b. below. 2a. Date of retirement or receipt of compensation *(Month, day, year)*	2b. Date of birth *(Month, day, year)*

I certify that the above information given in Part D has been obtained from, and correctly reflects, official records and the employee named had Federal Employees' Option C – Family Life Insurance on the **Date of the Death** of the employee's family member.

3. Signature of authorized agency official	4. Name of agency
5. Name of authorized agency official *(Type or print)*	6. Mailing address of agency, including ZIP Code
7. Title	
8. Date signed *(Month, day, year)*	9. Commercial telephone number *(including area code)*

Instructions to Claimant

1. **To Avoid Delay**
   (a) Read these instructions carefully.
   (b) Type or print in ink.

2. **Completion of Claim**
   Parts A, B and C should be completed by the claimant (usually the insured employee, retiree, or compensationer).

3. **Definition of Terms**
   The term “recognized natural child” used in Part B, Item 9, means a child born out of wedlock whom you recognized as your child during the child’s lifetime. In addition, at the time of the child’s death, he/she must have either lived with you in a regular parent-child relationship or been dependent on you financially. If you have any questions as to whether your child meets the above definition, contact your personnel office or retirement system.

   The term “disabled dependent child 22 yrs. or over” used in Part B, Item 9, means a child who was incapable of self-support because of a mental or physical disability which existed before the child became 22 years of age. You must submit documentation with this claim to substantiate the disability.

4. **Evidence Required**
   A certified death certificate must be submitted with this claim (a photocopy is not acceptable). This record may be obtained from the Bureau of Vital Statistics or equivalent agency. Failure to submit a certified death certificate will delay settlement of this claim. Additional evidence may be required.

5. **If Assistance is Needed**
   If you need assistance in completing this claim, contact the local personnel office of your department or agency if you are an employee or the Office of Personnel Management if you are a retiree or compensationer.

   If you need further assistance, you may write the Office of Federal Employees’ Group Life Insurance, 200 Park Avenue, New York, NY 10166-0188 or call the OFEGLI Service Representative, toll-free, at 1-800-OFE-GLIA (1-800-633-4542).

6. **Where to Send Claim**
   If you are an active employee, forward completed claim form and the death certificate to the local personnel office of the department or agency in which you are employed. If you are retired or receiving Federal Workers’ Compensation, forward completed claim form and the death certificate to:

   Office of Personnel Management
   Retirement Operations Center
   Attention: FE6-DEP
   Boyers, PA 16017

   Your employing office or OPM will then verify your family insurance status and forward the certified claim and death certificate to the Office of Federal Employees’ Group Life Insurance for payment or further action.

   DO NOT SEND YOUR CLAIM DIRECTLY TO OFEGLI.

7. **To Discontinue Option C Withholdings**
   If you no longer have any eligible family members, you should make arrangements to discontinue your Option C, Family Life Insurance, withholdings.

   Active Employees - Contact your employing office.

   Retirees or Compensationers - Contact:

   Office of Personnel Management
   Retirement Operations Center
   Attention: FE6-DEP
   Boyers, PA 16017
   412-794-8442

   Be sure to include your retirement or compensation claim number.