

CSRS DEATH-IN-SERVICE QUICK PAY

1. Employee's Full Name: _____
2. Other Names Used: _____
3. Date of Death: ____/____/____
4. Health Benefit Code at Death: _____
5. Social Security Number: ____-____-____
6. Date of Birth: ____/____/____
7. Retirement SCD: _____
8. Leave SCD: _____
9. Final Salary: \$ _____
10. Is There Part-Time Service After 4/7/1986? _____ Yes _____ No
11. Active Military Service: _____ Years _____ Months _____ Days
12. Military Deposit Paid: ____ Yes ____ No
13. Date First Covered by CSRS: _____
14. Receiving Active Duty Military Retired Pay: ____ Yes ____ No
15. Is this a CSRS-Offset Case? ____ Yes ____ No
16. Retirement Code: _____
17. Spouse's Name: _____
18. Date of Birth: ____/____/____
19. Date of Marriage: ____/____/____
20. Spouse's Social Security Number: _____ - _____ - _____
21. Spouse's Telephone Number: Home (____) _____ Work (____) _____
22. Mailing Address of Spouse: _____

23. Children of the Deceased:
Minor: ____ Yes ____ No How Many _____
Student: ____ Yes ____ No How Many _____
Disabled: ____ Yes ____ No How Many _____
24. Was Death Due to Work-Related Illness or Injury? ____ Yes ____ No
25. Agency Name: _____
26. Agency Mailing Address: _____

27. Name of Agency Contact: _____
28. Commercial Telephone Number of Contact: (____) _____
29. Fax: (____) _____
30. Email Address: _____
31. Name of Payroll Office Contact: _____
32. Commercial Telephone Number of Contact: (____) _____
33. Fax: (____) _____
34. Signature of Certifying Official: _____
35. Printed name of Certifying Official: _____

SUBMIT COMPLETED FORM TO OPM AS SOON AS POSSIBLE - FAX to (724) 794-1112

FERS BASIC DEATH-IN-SERVICE

- 1. Employee's Full Name: _____
- 2. Other Names Used: _____
- 3. Date of Death: ____/____/____ 4. Social Security Number: ____-____-____
- 5. Date of Birth: ____/____/____ 6. Total Creditable Service ____ Years ____ Months
- 7. Final Salary: \$ _____ 8. Average High 3 Salary: \$ _____
- 9. Is this a Part-Time Case? ____ Yes ____ No 10. If Yes, give Tour of Duty at Death _____
- 11. Retirement Code: ____ 12. Was Death Due to Work-Related Illness or Injury? __ Yes __ No
- 13. Spouse's Name: _____
- 14. Date of Birth: ____/____/____ 15. Date of Marriage: ____/____/____
- 16. Spouse's Social Security Number: ____ - ____ - ____
- 17. Spouse's Telephone Number: Home (____) _____ Work (____) _____
- 18. Mailing Address of Spouse: _____

- 19. Agency Name: _____
- 20. Agency Mailing Address: _____

- 21. Name of Agency Contact: _____
- 22. Commercial Telephone Number of Contact: (____) _____ 23. Fax: (____) _____
- 24. Email Address: _____
- 25. Name of Payroll Office Contact: _____
- 26. Commercial Telephone Number of Contact: (____) _____ 27. Fax: (____) _____
- 28. Signature of Certifying Official: _____
- 29. Printed name of Certifying Official: _____

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