

# Claim for Dismemberment Benefits Federal Employees' Group Life Insurance (FEGLI) Program

#### Instructions

"You", "your" and "I" refer to the insured employee.

### Who completes this form?

Employees enrolled in the FEGLI Program who lose a limb or eyesight complete this form.

### How do I complete this form?

Complete Part A and ask your physician or other healthcare provider to complete Part C. Then give the form to your human resources of fice.

## Should I attach anything to this form?

Yes. Attach copies of all medical reports from treatment you received for this accident. Also attach any police, traffic or other reports about this accident

### How can I get help completing this form?

Contact your human resources office or call the Office of Federal Employees' Group Life Insurance (OFEGLI) at 1-800-633-4542.

### Can someone complete this form on my behalf?

Yes. If you are physically or mentally unable to complete this claim form, someone else can complete it for you and attach a short explanation of the reason you are unable to complete this form. Items 1-8 of Part A and all of Parts B and C should be about you, but the person completing this form should sign his/her name and give his/her address and telephone number.

Part A - Employee's Statement										
1. Your name (Last, first, middle)			2. Date of birth (mm/dd/yyyy)	3. Social Security number						
Your department or agency, including bureau or division     5. Location of er		employment (City, state and ZIP code)	6. Date of accident (mm/dd/yyyy)							
				7. Place of accident (City and State)						
8. Give a brief description of the accident.										
All statements I made on this claim form are true. I information requested about this claim.	have not knowingly	left out a	anything related to this claim. I authorize my	ohysician or other healthcare provider to release any						
Your Signature		Address								
Telephone number	Date (mm/dd/yyyy)									
(day)										
(evening)										

### **Employing Agency's Instructions**

Please help the employee complete this claim form, if necessary. The employee should return this form after the physician or ot her health care provider completes Part C. Complete Part B and send this form to:

> Office of Federal Employees' Group Life Insurance PO Box 6080 Scranton, PA 18505-6080

Part B - Agency's Certification								
<ol> <li>Annual rate of basic pay for Basic Life insurance purposes on the d</li> <li>Was the employee covered by Option A on the date of the accident</li> </ol>	<b>*</b>	\$ Date of election (mm/dd/yyyy)						
I certify that this information correctly reflects of ficial records and that the employee was covered by Federal Employees' Group Life Insurance on the date of the accident.								
Signature of authorized agency official	Name of agency							
Name of authorized agency official (type or print)	Mailing address of agenc	y, including Z	IP code					
Title								
Date (mm/dd/yyyy)	Telephone number ( ) Area code			Fax numb ( Area cod	)			



Part C - Physician's Statement									
1. Name of patient	2. Date of Birth (mm/dd/yyyy)								
3. Date of accident (mm/dd/yyyy)	of this injury (mm/dd/yyyy)	5. Date of last treatment (mm/dd/yyyy)							
6. Describe the exact nature, location, and extent of all injuries sustained. (Attach all medical reports relevant to the treat ment of the injury)									
7. Were the injuries described solely responsible for the	oss of limb or eyesight?	YES  NO   Give the particulars of any cause or causes (including disease) which contributed to the loss, in the space to the left. (Explain on a separate sheet if necessary)							
Complete for Limb Amputa	ations Only	Complete for Loss of Vision Only							
8. Which limbs were severed or amputated?		13. Give the date of exam and vision b	efore the ac	ccident.					
		<b>1 5</b>		Uncorrected	Corrected				
On what date(s) did the severances or amputations oc	cur?	Date: (mm/dd/yyyy) (Snellen Notations)	Right eye Left						
State the exact point where the amputation was performed for each limb lost. If the severance or ampuknee joint, indicate in item 12 on the chart below the	eye  14. State the loss of vision.								
	15. Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notation) or less with correction, and the vision remaining in each eye on that date.								
		Date: (mm/dd/yyyy) (Snellen	Right	Uncorrected	Corrected				
		Notations)	eye Left						
			eye						
11. Reason for amputation(s)?		16. Give the date and vision found on I	ast eye exa		O				
		Date: (mm/dd/yyyy) (Snellen Notations)	Right eye	Uncorrected	Corrected				
	(Notations)	Left eye							
		17. Is recovery of useful vision possible		on or treatment?					
		Right eye Operation	No Tre	Yes No eatment					
		Left eye Operation	₩.	eatment					
12. CHART		18. If eye is enucleated, give date.	1 1						
RIGHT LEFT RIGHT	LEFT	19. If fields of vision are contracted, sh	ow contracti	ion on chart below . Right Eye					
I certify that all of my statements are true	150° 120° 120° 120° 10° 10° 10° 10° 10° 10° 10° 10° 10° 1								
knowledge and belief.	Office address - number and street								
Physician's Signature	Date (mm/dd/yyyy)	City, state and ZIP code							
Physician's Name (type or print)		Telephone number		Fax number					
	Area code		Area code						

