# 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 office.

**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

4. Your department or agency, including bureau or division

5. Location of 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 have not knowingly left out anything related to this claim. I authorize my physician or other healthcare provider to release any information requested about this claim.

Your Signature

Address

Telephone number

(day)

(evening)

Date (mm/dd/yyyy)

## Employing Agency's Instructions

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

**Office of Federal Employees' Group Life Insurance**
**PO Box 2627**
**Jersey City, NJ 07303-2627**

## Part B - Agency's Certification

1. Annual rate of basic pay for Basic Life insurance purposes on the date of the accident → $

2. Was the employee covered by Option A on the date of the accident? NO ☐ YES ☐ If "YES," → Date of election (mm/dd/yyyy)

I certify that this information correctly reflects official 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 agency, including ZIP code

Title

Date (mm/dd/yyyy)

Telephone number ( ) Area code

Fax number ( ) Area code

Do not use previous editions

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## Part C - Physician's Statement

1. Name of patient

2. Date of Birth (mm/dd/yyyy)

3. Date of accident (mm/dd/yyyy)

4. Date first consulted because 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 treatment of the injury)

7. Were the injuries described solely responsible for the loss 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 Amputations Only

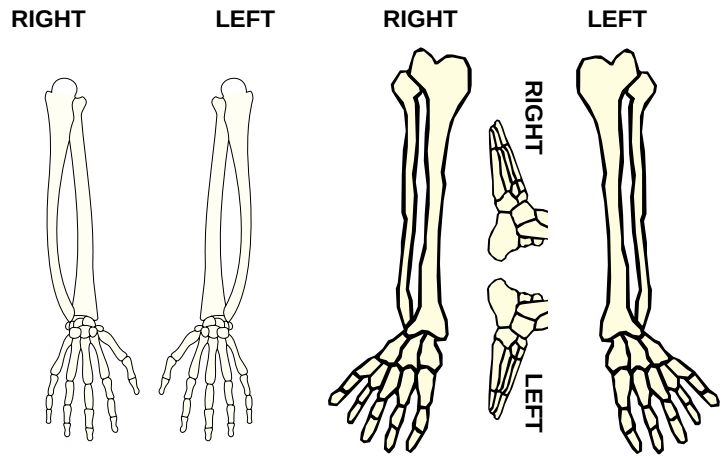
8. Which limbs were severed or amputated?

9. On what date(s) did the severances or amputations occur?

10. State the exact point where the amputation was performed or where the severance occurred for each limb lost. If the severance or amputation was below the elbow or knee joint, indicate in item 12 on the chart below the exact point of severance.

11. Reason for amputation(s)?

12. CHART




### Complete for Loss of Vision Only

13. Give the date of exam and vision before the accident.

Date: (mm/dd/yyyy)

(Snellen Notations)

| | Uncorrected | Corrected |
|---|---|---|
| Right eye | | |
| Left 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 Notations)

| | Uncorrected | Corrected |
|---|---|---|
| Right eye | | |
| Left eye | | |

16. Give the date and vision found on last eye examination.

Date: (mm/dd/yyyy)

(Snellen Notations)

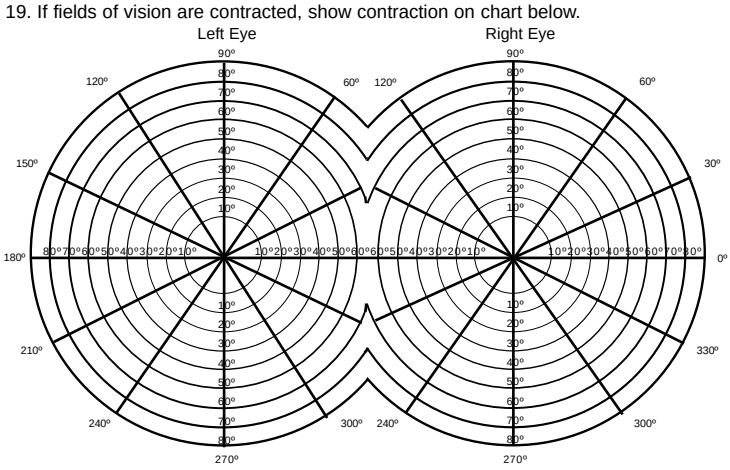
| | Uncorrected | Corrected |
|---|---|---|
| Right eye | | |
| Left eye | | |

17. Is recovery of useful vision possible by operation or treatment?

| | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|
| Right eye | Operation | | | Treatment | | |
| Left eye | Operation | | | Treatment | | |

18. If eye is enucleated, give date.

19. If fields of vision are contracted, show contraction on chart below.




**I certify that all of my statements are true to the best of my knowledge and belief.**

Physician's Signature

Date (mm/dd/yyyy)

Physician's Name (type or print)

Office address - number and street

City, state and ZIP code

Telephone number ( ) Area code

Fax number ( ) Area code



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